

CA20N

Z 1

83H021

3 1761 11850159 2

GOVT PUBNS



Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence
for
April 26, 1984

VOLUME 136

OFFICIAL COURT REPORTERS

Angus, Stonehouse & Co. Ltd.,
14 Carlton Street, 7th Floor,
Toronto, Ontario M5B 1J2

595-1065



ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

Hearing held on the 8th Floor,
180 Dundas Street West, Toronto,
Ontario, on Thursday, the 26th
day of April, 1984.

- - - - -

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

- - - - -

APPEARANCES:

P.S.A. LAMEK, Q.C.)	Commission Counsel
E. CRONK)	
D. HUNT)	Counsel for the Attorney
L. CECCHETTO)	General and Solicitor General
	of Ontario (Crown Attorneys
	and Coroner's Office)
I.G. SCOTT, Q.C.)	Counsel for The Hospital for
I.J. ROLAND)	Sick Children
M. THOMSON)	
R. BATTY)	
B. PERCIVAL, Q.C.)	Counsel for The Metropolitan
D. YOUNG)	Toronto Police
W.N. ORTVED	Counsel for numerous doctors
	at The Hospital for Sick
	Children
F. KITELY)	Counsel for the Registered
B. SYMES)	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children

(Cont'd)...



APPEARANCES: (Continued)

D. BROWN	Counsel for Susan Nelles - Nurse
C. THOMSON, Q.C.) G.R. STRATHY) P. RAE)	Counsel for Phyllis Trayner - Nurse
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
B. KNAZAN	Counsel for Mrs. M. Christie - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
F. SHANAHAN	Counsel for Mr. & Mrs. Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)

Digitized by the Internet Archive
in 2024 with funding from
University of Toronto



INDEX OF WITNESSES

<u>NAME</u>	<u>Page No.</u>
<u>TRAYNER</u> , Phyllis; Resumed	1212
Cross-Examination by Mr. Percival (Cont'd)	1212

INDEX OF EXHIBITS

<u>No.</u>	<u>Description</u>	<u>Page No.</u>
397	Anonymous letter to Phyllis Trayner with attached envelope.	1294



A/BM/ak

1
2 --- Upon commencing at 9:30 a.m.

3 THE COMMISSIONER: Yes, Mr. Percival.

4 MR. PERCIVAL: Thank you,
5 Mr. Commissioner.

6 PHYLLIS TRAYNER, Resumed

7 CROSS-EXAMINATION BY MR. PERCIVAL: (Continued)

8 Q. Mrs. Trayner, I want to deal
9 with one last matter involving the death of Baby
10 Lombardo that I neglected to cover yesterday after-
11 noon. That has to do with respect to the special
12 formula bottle that we spoke about yesterday having
the name of Stephanie Lombardo on it.

13 A. Yes.

14 Q. Do you remember we talked
15 about that yesterday?

16 A. Yes.

17 Q. Nurse Ganassin at 9 o'clock and
18 at 12:00 midnight and at 3:00 a.m. on all three
19 occasions, at least according to her sworn testimony,
20 indicated that the baby fed well and seemed well
21 after each of those feedings. Do you remember me
reading that to you yesterday?

22 A. Right.

23 Q. And within 30 minutes of the
24 last feeding at 3:00 a.m., if Nurse Ganassin's
25



1
2 evidence is correct, you apparently found the baby
3 blue and in distress.

4 A. Right.

5 Q. Now, Ganassin had apparently
6 used a formula bottle with Lombardo's name on it.
7 I suggest that night ~~there~~ was only you and Nurse Ganassin
8 on that ward certainly between 12:00 midnight and 3:00
9 a.m. and it would have been a simple matter for
10 someone to unscrew the top of the Lombardo formula
11 bottle and add some parenteral digoxin and then
12 Nurse Ganassin at 3:00 a.m. unsuspectingly and
13 quite innocently feeding that baby. Do you agree
with me?

14 A. That's a possibility.

15 Q. All right. Well, can you
16 think of any other possibility how that Baby Lombardo
17 could have, after exhumation, as I said before, a
18 chock full of digoxin in that nine day old baby
19 when she had never been prescribed in the nine days
20 of her life digoxin? Can you give me any other way
21 that that could have been done that you can think
of at this point?

22 A. No, I can't.

23 Q. Thank you. I suppose the
24 other is if some unauthorized person came in and
25



1
2 injected the parenteral digoxin into the buretrol
3 which was infusing into that child as well with
4 the sage pump; that's the other alternative?

5 A. Yes.

6 Q. You can't think of any other
7 alternative?

8 A. No, I can't.

9 Q. Thank you. May I turn,
10 Nurse Trayner, to the death of Janice Estrella. I
11 think if we look at 383 that baby died 22 days later
12 after the death of Baby Lombardo and you were
13 working a long night shift that night as team leader
14 with Sui Scott, Marianne Christie and Janet Brownless
15 on Ward 4A and Janice Estrella died at about 3:22 a.m.
Is that your recollection?

16 A. Yes.

17 Q. Extensive evidence has been
18 given by you at this Commission at the preliminary
19 hearing and you will be thankful to know I don't
20 want to go through it exhaustively but I want to
21 try to understand your evidence fully. You are
22 aware from looking at the chart that Janice Estrella
had the digoxin on hold for some three days before
this particular shift when she died?

23 A. That's right.
24
25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. As I understand your evidence Janice Estrella was on constant care on the night shift she died and was assigned to Sui Scott?

A. That's right.

Q. And she was in Room 423 which was a single bed room and it was coincidentally the same room that Allana Miller subsequently died in?

A. Yes.

Q. You were the team leader that night and Sui Scott was on constant care and there was in fact a television in that room?

A. That's right.

Q. As I understand your evidence you recall relieving Sui Scott before midnight and your evidence before this Commission is that when you relieved Sui Scott before midnight you never left the side of Janice Estrella during that break?

A. If I relieved her for the 10 o'clock break I didn't leave the room.

Q. All right, thank you. Well, you didn't leave the room, you wouldn't leave her side I gather?

A. That would be right.

Q. That's the only baby in there and it is the only cot in there?



1

2

A. Right.

3

4

5

6

7

8

9

10

11

A. That's right.

12

13

14

15

16

A. Right.

17

18

19

20

A. Right.

21

22

23

24

25

Q. As I understand your evidence, your sworn evidence before this Commission, that after midnight on a number of occasions you came by Room 423 and asked Sui Scott whether or not she would like relief and she kept saying to you, no, I've got a good book and I am seeing a good movie on television and thanks but I don't need you to relieve me for dinner break. Does that fairly synopsise your evidence?

Q. And apparently according to your evidence the terminal events commenced shortly after 2:30 and you were alerted by Sui Scott as to that and you came in and the codes were called and the resuscitation attempt started.

Q. And the baby died then at 3:22 and by my count that's the 18th unsuccessful resuscitation by your team if I can count it up.

Q. As I further understand your evidence, your sworn evidence before this Commission, you categorically denied that you ever tried to do constant nursing care on Janice Estrella let alone



1
2 any other baby that you ever cared for under constant
3 nursing care by going to the nursing station and
4 turning on the monitor?

5 A. That's right.

6 Q. And you are aware of course
7 that the evidence of Sui Scott at this Commission,
8 her sworn evidence is that she was relieved by you
9 for coffee break before midnight, that you relieved
10 her again at 1:30 for dinner, that she was only at
11 the nursing station for a short time between 30 and
12 35 minutes and that you came back to the nursing
13 station and turned on the monitor and commenced
14 doing some paper work. Do you recall having read
15 that in her evidence with respect to what she said
16 occurred that night?

17 A. Yes, I do.

18 Q. And the evidence as I understand
19 it is that after 3 or 10 minutes, and that is
20 variously described, she became nervous, poured
21 herself a cup of coffee, went back to Room 423
22 because the baby was alone and shortly after that
23 the baby's terminal events commenced. Is that again
24 your recollection of what she said?

25 A. Yes.

Q. Now, you have stated many



1
2 times to various counsel in these proceedings that
3 your version of the events that night is correct
4 and you still say that?

5 A. Yes.

6 Q. I want to point out to you
7 that there does not appear to be any corroboration
8 for your version because there seems to be, and you
9 are aware of this, that both Nurse Parcels and
10 Nurse Christie seem to adopt and confirm the
11 evidence of Sui Scott. Are you aware of that?

12 MR. STRATHY: Mr. Commissioner,
13 if I may. I'm not sure it is fair to say that those
14 witnesses adopt holus bolus --

15 MR. PERCIVAL: I didn't say that.
16 I said adopt her version of the fact that you
17 relieved her after midnight and on some occasion
18 both you and Sui Scott were at the nursing station.

19 MR. STRATHY: I think that clarifies
20 it then.

21 MR. PERCIVAL: Q. Do you understand
22 that that is the evidence of Nurse Parcels and
23 Nurse Christie?

24 A. I wasn't aware that they had
25 said that I had relieved her. I am under the
impression that they said that they saw us at the



1
2 nursing station together.

3 Q. Well, who else would relieve
4 her that night? Who else would relieve aside from
5 you? I think you have already conceded to
6 Mr. Lamek that you would be the one most likely to
7 as team leader.

8 A. Most likely to, yes.

9 Q. All right. In any event,
10 your evidence is that you swear that you did not
11 relieve her after midnight for the lunch break. Now,
12 I want to end up taking that, if your evidence is
13 correct and accepted by this Commission, it would
14 seem to me clear that from 7:15 p.m. when your
15 team came on that long night shift and up until
16 the terminal events were noticed by Sui Scott at
17 2:30, between you and Sui Scott 100 per cent of the
18 time this baby was being attended on a constant
19 care basis.

20 A. That's right.

21 Q. All right. And never at any
22 time for the seven or eight hours prior to the
23 commencement of the terminal events was that baby
24 alone, again, if I accept all of your evidence.

25 A. That would be correct.

Q. All right. So, the baby was



1
2 either with your or with Sui Scott at all times in
3 that single room with the single cot in Room 423.

4 A. Well, Sui Scott had to get
5 medication for the baby and I don't know what she
6 did at that time.

7 Q. Well, we will have to rely
8 upon what her evidence is.

9 A. Okay.

10 Q. All right. You don't have
11 any recollection on that. But you say that maybe
12 at some point in time in going to get medication
the baby was left alone and unattended?

13 A. It may have been, I don't
14 know.

15 Q. All right. Now, if Sui Scott
16 swears she never gave digoxin to that baby on that
17 shift and you have sworn that you never gave digoxin
to that baby that shift, and I gather that is so?

18 A. That's right.

19 Q. And if a pharmacologist's
20 evidence is accepted that this baby must have
21 received digoxin within two, three, four hours
22 prior to the onset of terminal events, do you have,
23 before this Commission, any explanation as to when
24 and under what circumstances that could have occurred?
25



1

2

A. No, I don't.

3

4

Q. And if your evidence is
accepted you never left the side of Baby Estrella
during the break before midnight?

5

6

A. That's right.

7

8

Q. You never fell asleep during
that time?

9

A. No.

10

11

Q. You don't recall anybody
coming in and putting something in the buretrol
while you were sitting beside the bed of that baby?

12

A. No.

13

14

15

16

17

18

Q. All right. Would you agree
with me that if that is the pharmacology evidence
and if Sui Scott was there all the time she was
and you were there all the time you were that somehow,
somehow digoxin got into the buretrol and into the
baby which caused its death, if the evidence of
the pharmacologist is correct?

19

A. Yes.

20

21

22

23

24

25



B/DM/LN

1

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Did you ever in the course of your visits and rounds, in the course of the seven hours prior to the onset of terminal events, ever come to the room and see Sui Scott asleep?

A. No, no, I didn't.

Q. That would be a most unusual event I gather if somebody was supposed to be giving very very careful attention to a child and constant nursing care.

A. Yes.

Q. And when I am talking about constant nursing care, do I take it that while vital signs in constant nursing care may be recorded on an hourly basis, that that doesn't mean that the nurse on constant nursing care, because she is looking after only one baby, may chose to take vital signs every fifteen minutes if the condition of the baby is so, and not record it.

A. Right.

Q. And in fact would you agree with me that as team leader with your experience that may be something that a nurse should be doing on constant nursing care to make sure that there is no change for the worse in that child.

A. We would be constantly assessing



2
1
2 the child.

3 Q. Thank you. Under constant
4 nursing care, whether it was you or Sui Scott that
5 day, both you and Sui Scott would be vigilant with
6 respect to the welfare of that child, Janice
7 Estrella.

8 A. Yes.

9 Q. Certainly it is not likely if
10 you were vigilant that someone could come in and put
11 something into the buretrol without you or Sui
12 Scott knowing it.

13 A. That would be correct.

14 Q. Do I understand that nurses
15 during this nine month period were only authorized
16 to give digoxin elixir by mouth to these babies, and
17 they were also authorized, I gather, to give tablets
18 to the older children.

19 A. That's right.

20 Q. They were not supposed to give
21 digoxin into the buretrol if the child was on
22 intravenous.

23 A. No, we were not.

24 Q. They were not authorized to give
25 it by the push method as we have heard described in
this Commission?



3

1

2

A. No, we are not.

3

4

5

6

7

8

Q. I want to ask you something with respect to how long you would think, if someone, for whatever motive they had, how long it would take someone to take say even ten centimetres or ten millimetres of adult strength digoxin, how long it would take for them to put it into the buretrol? Do you have any opinion in relation to that?

9

10

A. Just the amount of time that it would take to give an antibiotic intravenously.

11

12

Q. Are we talking in terms of a matter of seconds?

13

14

A. Probably about a minute, shorter than a minute.

15

16

17

Q. Perhaps I can refresh your recollection about what you said on another occasion with respect to that question; the preliminary hearing, Volume 4, page 1198.

18

THE COMMISSIONER: Page what please?

19

MR. PERCIVAL: 1198 Mr. Commissioner.

20

MR. STRATHY: That is not Volume 4.

21

MR. PERCIVAL: I'm sorry, I made the mistake of binding these all together Mr. Commissioner.

22

MR. STRATHY: It is Volume 6.

23

MR. PERCIVAL: Thank you very much.

24

25



1

2

3

Q. You were asked these questions
by Mr. Cooper back in the spring of 1982;

4

5

6

"Q. How long would it take to
administer ten cc. directly into the
tube of an intravenous?

7

8

A. Hm-mm. Well we can give
antibiotics within minutes into the
buretrol.

9

10

Q. Into the buretrol within
minutes?

11

12

13

14

A. Hm-mm.

Q. Well all it really involves
is putting a needle in the buretrol and
squirting the handle.

15

16

17

A. And squirting, yes.

Q. Actually it is a matter of
seconds, isn't it, if you want to
administer it quickly?

18

19

20

A. Sure.

Q. Is that right?

A. Hm-mm."

21

22

Do you recall being asked those
questions and giving those answers?

23

24

25

A. Yes.

Q. So do I take it that it is a



5 1
2 matter of seconds, it may even be a matter of five,
3 ten or fifteen seconds, all it would take for
4 someone with a motive to do something to this child
5 and wanted to do it quickly could put ten millimetres
6 or ten cc. of digoxin into the buretrol on any IV
7 on your ward in that nine month period.

8 A. Okay.

9 THE COMMISSIONER: Is there any
10 advantage of putting in medicine slowly into the
11 buretrol? If you are going to give a child medicine
12 presumably it is controlled by the buretrol,
13 controlled as to how fast it goes into the child.

14 THE WITNESS: Right.

15 THE COMMISSIONER: It really doesn't
16 matter whether you put it in fast or slow, or does it?

17 THE WITNESS: No. When you are giving
18 the antibiotics you still have to release some fluid
19 from the bag.

20 THE COMMISSIONER: Yes.

21 THE WITNESS: So that takes another
22 few seconds to do that and then to put the syringe
23 in.

24 MR. PERCIVAL: Maybe I can take it one
25 step further Mr. Commissioner.

THE COMMISSIONER: Yes.



6

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Let's suppose again for some same nefarious purpose a person would like to inject 10 cc. of whatever medication they want into a child and do it quickly, is there anything - again is it a matter of seconds for them to inject it below the buretrol and into the IV tubing or it is almost very quickly within a matter of seconds infusing into the body of the baby.

A. That would be a possibility too.

Q. If one wanted to do it quicker and have the effect more quickly, that would be a faster way of doing it rather than putting it into the buretrol, do you agree?

A. Okay.

Q. But again we are talking a matter of seconds to do either one of those.

A. Okay.

Q. Well, is your okay, do you mean, yes?

A. Yes.

Q. Thank you very much. Now in January of 1981, and I am talking about the baby Estrella, I gather at that particular time digoxin in whatever form you wanted to get it, whether in tablets, elixir, paediatric ampules, parenteral ampules, all of this were in the medication room



1

2

which is unlocked?

3

A. That's correct.

4

5

6

7

8

Q. So none of that was under close supervision sofar as inventory or anything else, they were in the medication room which is unlocked 24 hours a day in January of 1981, for anybody to take what they wanted and we will get to that shortly, but it was freely accessible.

9

A. That's right.

10

11

12

Q. You didn't have to worry about going out to get it at a drug store in January of 1981.

13

A. Well we -

14

Q. If you had access to the medication room.

15

A. Oh, well - yes.

16

17

18

19

20

Q. I am not talking about just the medication room on wards 4A and 4B, how about many of the other medication rooms throughout the various wards in the Hospital for Sick Children, was digoxin kept there?

21

A. I believe so, yes.

22

23

24

25

Q. So we are probably talking not just two medication rooms were freely available for people to have access to the medication room, we are



8

1

2

probably talking about 15 or 20 medication rooms
throughout this Hospital, and perhaps throughout
many other hospitals in the Province of Ontario?

5

A. That's correct.

6

7

Q. And let's talk in terms of the
parenteral digoxin ampules, they are not very large,
are they?

8

9

A. No, the paediatric ones are
smaller than the adult size.

10

11

12

13

Q. The adult ones are even not that
small, you can put one or two in the palm of your
hand and close your fist and still not have them
visible, isn't that true?

14

15

A. You mean they are not that
small, or they are that small?

16

17

Q. They are small.

18

19

20

21

22

23

24

25

A. Right.

Q. Yes. So do I take it if
somebody wanted to, for whatever purpose, to go into
a medication room and pick up some parenteral ampules
of digoxin, one could easily get four or five of
these ampules and put them in their pocket and walk
around and it would be completely and totally
unnoticed, or could be unnoticed by anybody else in
that hospital.



9

1

2

A. Yes.

3

Q. You could put it in one's purse,

4

if you had a purse?

5

A. I suppose so, yes.

6

Q. So it is not bulky is what I am

7

getting to.

8

A. Right.

10

Q. While I am on this subject, and

11

I have said I had some visualization, quite

12

erroneously, about the digoxin in these bottles.

13

I am not going to get into it except to say the

14

elixir that was in the medication rooms in the

15

spring of 1981, I had a visualization and you will

16

forgive me and perhaps it was obviously erroneous,
of a large bottle, and we are not really
talking about a large bottle that was in the medica-
tion room, is it?

17

A. No, we are not.

18

Q. And it is 100 cc. or a four

19

ounce bottle?

20

A. Right.

21

Q. And it is half a cup, the size

22

of the bottle?

23

A. Right.

24

Q. So we are talking about again

25



1
2 a bottle that is very small, it could be put in a
3 man's pocket, a woman's purse and carried unnoticed.

4 A. Yes.

5 Q. So when we talk about, as Mr.
6 Lamek has said, about the missing bottle of digoxin,
7 we are talking about a small bottle?

8 A. Yes.

9 Q. Thank you. In any event if
10 someone, for whatever nefarious purpose they wished
11 to do so as far as Janice Estrella is concerned,
12 people could have on their person, four, five, ten
13 ampules of parenteral digoxin on their person and
14 walk around unnoticed on your ward the night Janice
15 Estrella died?

16 A. Yes.

17 Q. If they wished to?

18 A. Yes.

19 Q. Thank you. You noticed no one
20 unusual on that ward that evening that you can recall,
21 save and except the members of your team and the
22 doctors?

23 A. That's right.

24 Q. Now I want to take the second
25 scenario, because I accepted all your evidence in
the first scenario. If we take the second scenario



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Trayner,
cr. ex. (Percival)

1232

1

11 2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

that you are not prepared to accept; in other words,
that you left baby when you were supposed to provide
constant nursing care, when you relieved Sui Scott
after midnight and just before the terminal events
occurred, and went back to the nursing station and
turned on the monitor? I want you to accept that
as a premise if the Commissioner chooses to accept
that version.



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26apr84
C
EMTrc

Do I take it that in that short period of time, whether it is three or ten minutes, it would be fairly easy for anybody, anybody on that ward, to have walked into Room 423 and given parenteral digoxin to Baby Estrella that caused its death?

A. Yes.

Q. All right. And 423, as I look at the ward diagram, 423 is some way away from the nursing station?

A. Yes.

Q. And you can't even, as you sit at the nursing station, see the doorway to 423, can you?

A. If you are sitting right out at the front of the nursing station, you may be able to. If you are at the back, you can't.

Q. But I gather at three o'clock in the morning the corridors are not well lit?

A. That is right.

Q. All right. And you would have to be really looking to see that, if somebody went in there and did that to Janice Estrella if in fact you were at the monitor by the nursing station?

A. Right.



1

C2

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. If your evidence is not accepted and that of Sui Scott is preferred, I was thinking in terms of the lapse of time that it took from the time your team started shift at seven o'clock till the time the terminal event started at two or three o'clock. My calculation is there is about seven hours or 420 minutes.

Somebody must have been pretty clever if that is what happened; waited and waited and waited and waited until in the magic three to ten minutes that that baby was alone to inject that digoxin. Somebody pretty clever and somebody that knew what was going on on that ward. Wouldn't you agree with me?

A. Yes.

Q. All right. Somebody that knew patterns, knew schedules and knew that that baby was unattended even though it was supposed to be under constant care. Again if Sui Scott's evidence is accepted.

A. Right.

Q. Now I think you talked about, and this leads me into the next subject, Mrs. Trayner, unauthorized persons on the ward at night. And I think Mr. Hunt started into this in Volume 134,



C3

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

page 918 and into 926, but I think you went so far as to agree with him that at night after midnight by and large whoever was doing it was not likely the cleaning staff of The Hospital for Sick Children or anyone connected with it, if in fact we are talking about 8, 10, 15 murders?

A. Yes.

Q. And then you started to talk and you left it open, as I see it, talking in terms of the medical staff, and I think you agreed with him that we really are down to the question of it is medical staff whether you talk in terms of doctors, Fellows, residents, nurses or nursing assistants.

Is there anybody else that is not encompassed under the words "medical staff"?

A. No.

Q. All right. So we are down to this point at least, according to your evidence, that the type of person or the category of person who might be doing these heinous things on this floor during the nine-month period has to come within the grouping of medical staff?

A. Well, that would be a fair assumption, yes.

Q. Well, it is a distinct and



1

C4

2

total probability, isn't it?

3

A. Right.

4

Q. And I want to deal with that aspect of the matter. You have looked at the 29 charts, and I think you agreed with me yesterday you looked at the 29 charts involving the 29 deaths, the arrests, the unsuccessful resuscitations with which you were intimately concerned during the nine-month period?

5

6

7

8

9

10

A. Right.

11

Q. And did you look in the course of those 29 charts to see any common thread, a doctor showing up in the chart on a consistent, consistent, consistent basis in 29 deaths? Did you?

12

13

14

A. No.

15

Q. Did you see any of that?

16

A. No.

17

Q. And I gather if we talk in terms of the giving of medication, I gather it is a rather unusual event that occurred during the nine-month period where a physician would be actually administering the medication himself, and whether it is into the buretrol, into the push method, or however, that was more unusual than the situation where he would order something and the nurse would do it. Do

18

19

20

21

22

23

24

25



C5

1

2

you agree with me?

3

A. You mean more unusual or...?

4

Q. No, if nurses did it 99

5

times, the doctors would do it once. Is that a fairly
good -- the odds of medication in general on the ward
to the babies in the nine-month period. And I am
excluding arrest situations, please.

8

A. Okay, yes.

9

Q. So we are not talking about

10

arrest situations; we are talking about the normal
day-to-day activities on this ward. 99 per cent of
the time the nurses are administering the medications;
1 per cent of the time the residents or the staff
doctors or the Fellows are administering the medica-
tion?

14

15

A. Yes.

16

Q. And do I take it that when a

17

doctor or resident or Fellow would administer the
medication, he wouldn't go to the medications room
and get it himself; he would ask a nurse to get it.
Isn't that the protocol that occurred in 4A/4B in
that nine-month period?

20

21

A. Yes.

22

Q. And it would be most unusual

23

I suggest to have a physician going into the medications

24

25



C6

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

room or getting something from beside the narcotics cupboard or being in there? Is that not fair? It is an unusual situation to go in there alone?

A. I suppose so, yes.

Q. Well, have you ever seen one? Did you ever see one in the nine-month period?

A. Yes.

Q. When?

A. Doctors going in to get spoons.

Q. Well, all right. So I gather you saw them; they came out with a spoon. Anything else? Did you ever see one go in there and help himself to medication in the medications room in the nine-month period, that you can recall?

A. I can remember one doctor going in to get a couple of aspirins.

Q. All right. Anything else?

A. No.

Q. All right. So do I take it that by and large most of the time the doctor, if they attended a patient in one of the rooms, would say to the nurse "I am going to order so and so and I will fill it out. Will you go and get the medication in the medications room and bring it back." Right?

A. Yes.



1

C7

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. You as a nurse would remain
as you brought the medication back with the doctor
while it was administered?

A. Yes.

Q. Because that was your patient?

A. Yes.

Q. And you would have to record
the fact that it was administered?

A. Right.

Q. And if he administered it,
you would still sign for it because it would have to
be recorded on the chart?

A. Well, we would sign that it
was given by a doctor.

Q. So you would be very specific
about that?

A. Yes.

Q. And you couldn't say you
witnessed that unless you remained with the doctor;
isn't that correct?

A. Right.

Q. Now I want to take the situation
where we are in the middle of the night. I gather
there is not too often staff men coming down to 4A/4B
after midnight except when there was an arrest



C8 1
2 situation like when Dr. Fowler came in after Justin
3 Cook died?

4 A. Right.

5 Q. Can you remember any other
6 time after midnight when a staff man came in after
7 midnight and before anything unusual occurred? Can
8 you think of any of these situations where that
occurred?

9 A. I thought Dr. Rose had come
10 in one night after an arrest.

11 Q. All right. No, no. I'm
12 talking about before an arrest.

13 A. Oh, no.

14 Q. Because we are trying to find
15 out where we are at, who are likely to be suspected
16 if in fact there was an unauthorized medication given
to these patients. Do you understand?

17 A. Yes.

18 Q. Can you remember -- can you
19 think of any staff man you can recall in that nine-
20 month period who came in after midnight and before
the arrest started?

21 THE COMMISSIONER: I hope there is
22 not some difficulty of communication. That means
23 any doctor at all, not just...
24
25



C9

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MR. PERCIVAL: I am talking about
staff men, Mr. Commissioner.

THE COMMISSIONER: Oh, I'm sorry.

MR. PERCIVAL: I want to get to
residents and --

THE COMMISSIONER: Oh, I beg your
pardon. I was the one without the communication;
not you.

MR. PERCIVAL: I apologize, sir.

THE COMMISSIONER: No, no.

MR. PERCIVAL: Q. Mrs. Trayner,
you understand when I said staff man what it meant?

A. Yes.

Q. Perhaps I should have defined
the term. We are talking about men. I gather you
can't think of any time when a staff man came in
prior to an arrest after midnight?

A. No. No, I can't.

Q. Now let's take it to the
next thing. There are Fellows and there are residents?

A. Yes.

Q. And the Fellow -- is there
a cardiac Fellow that is assigned to 4A/4B on a
regular basis?

A. Yes.



1
C10 2 Q. And is there one or more than
3 one?
4 A. Well, there's more than one
5 Fellow but one is probably assigned to the floor.
6 Q. All right. And is he
7 assigned on more than a one-month or two-month basis?
8 A. It was my understanding that
9 they took turns.--
10 Q. All right.
11 A. -- for the night.
12
13
14
15
16
17
18
19
20
21
22
23
24
25



1

2

D/BM/ak

3

4

5

Q. So, do I take it that if we are talking about fellows, again, you didn't see the same fellows show up every night when these arrests were taking place?

6

A. Well, I can't recall.

7

8

9

10

Q. So, there is no common thread of fellows, we can exclude them as the common thread, if I can use that expression, as being consistently there every time one of these babies arrested with which you were connected?

11

12

A. Well, I never thought of it at that time.

13

14

15

16

17

18

Q. I understand, I want you to think about it now, Mrs. Trayner, because, you know, you have left the impression, and maybe not with the Commissioner, but you left the impression with other people in the community that really the doctors might have been involved and that's why I am trying to explore that with you. Could we do it now?

19

A. Sure.

20

21

22

23

24

25

Q. All right. Can you tell me, would you agree with me that insofar as fellows are concerned again there is no common thread, statistically the same physician, the same fellow was not there on each and every one of these things,



1

2

they changed from day to day to day?

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. Well, they did change but I can't remember all the children, so, I can't remember who was there and who wasn't there every night.

Q. Well, again, if the fellow was there I gather he would leave some marks, some orders, some common thing within the chart. You would expect that on each of these babies that died?

A. Not necessarily, no.

Q. So, the fellow wouldn't record his presence on the ward even though the baby had died?

A. He may write a note, yes.

Q. But again statistically you don't see that, and you don't recall at this time that the same fellow was there on each and every one of these baby deaths?

A. No, I can't.

Q. All right. Well, let's deal now with the residents. Again, the residents I gather were residents that changed more often than the fellows, is that right? They were on one or two months rotations?

A. Yes, that's right.



1

2

3

4

5

6

7

Q. So, the fellows, for instance, we have heard about David Nelles. David Nelles was there I gather some time in the summer of 1980 and from time to time came back to the ward to visit his sister but he never came back to the ward to work, is that correct?

8

A. That's right.

9

10

11

Q. And he was on other rotations, orthopedic, burns, I don't know what else is there at the Hospital but he was in other rotations at other areas of the Hospital.

12

A. Right.

13

14

15

16

17

18

Q. And again so far as residents are concerned did you see any common thread throughout the course of the nine months where residents would consistently be there when children were dying with your team on that ward. Can you think of any resident that we should be thinking about who was there more often than any others?

19

20

A. I can't remember the children so I can't remember who was there all the time.

21

22

23

24

25

Q. So, do I take it that we go down the same as the fellows, so far as the residents are concerned you see no common thread there that you can recall at this time even?



1

2

A. Yes.

3

Q. After having reviewed 29 charts?

4

A. Yes.

5

Q. Thank you. Well then, do I

6

take it that at night the residents and the fellows,

7

although they're on call are not consistently on

8

the ward; in other words, they are not there 12 hours

9

of the 12 hour shift on long nights, they're on call?

10

A. That's right.

11

Q. And to be on call so that --

12

at night I gather they must sleep, as most of us

13

do, but nurses have to on long nights stay awake.

14

A. Right.

15

Q. And they come when they are

16

called?

17

A. Yes.

18

Q. And it would be rather

19

unusual I suggest to you to have residents and

20

fellows coming on to your ward unsolicited, uncalled

21

for and wandering around the ward and looking at

22

patients?

A. We have had the occasional

23

time when that has happened.

24

Q. All right.

25

A. They have been called down to



1

2

emergency in the middle of the night.

3

4

5

THE COMMISSIONER: No, no, I think the question was whether they come unsolicited, whether they come without being called.

6

7

8

9

10

THE WITNESS: Yes, they have. After seeing a patient in emerg. and if we had had a child that the doctor was concerned about earlier in the evening and was there because he had to pass our floor because he had to go back to bed he may just pop in again.

11

12

13

14

15

MR. PERCIVAL: Q. All right. Are we talking in terms of maybe four or five occasions when that occurred in the course of the nine month period that you can recall? Is that what we are talking about?

16

17

18

19

20

21

22

23

24

25

A. I don't know how many times, I just know that it has occurred.

Q. Well, it has occurred, but you see, we are dealing with 29 deaths and I'm wondering whether or not again in retrospect now four years later whether you can remember in trying to find out what really happened why people were there and a physician, a resident or a fellow being on there uncalled for would be an unusual event. Can you think of anything other than the occasions when they



1
2 would be wandering through the ward going back to
3 their bed after being called down to emergency, can
4 you recall any recurring theme?

5 A. No, I can't.

6 Q. And you were asked about this
7 back at the time of the preliminary hearing, and
8 this is in Volume 30, page 19, top of the page.
9 This is again by Mr. Cooper:

10 "Q. And I take it that it follows
11 that with respect to all of these
12 deaths that occurred in July, 1980,
13 August 1980 and into the fall and
14 winter of 1981 you as a team leader
15 saw nothing suspicious or out of the
16 ordinary with respect to anyone's
17 behaviour on the fourth floor that
18 led you to suspect that someone was
19 doing or had done something wrong,
20 isn't that right?

21 A. That's correct."

22 Do you remember being asked that
23 question by Mr. Cooper and coming to that answer?

24 A. Yes.

25 Q. And that was under oath?

A. Yes.



1

2

Q. And do you still say that today?

3

A. Yes.

4

Q. I'm prepared to accept that,

5

although, I have some reservations because it was

6

an interesting thing that struck me during the course

7

of Mr. Hunt's examination of you, I think it was

8

cross-examination, Volume 134, page 916. I want

9

to read it to you because I was struck by the answer

10

and it bothered me and that's why I want to come

11

back to it. The question put to you by Mr. Hunt at

line 6 and going through to 19 is as follows:

12

"Q. I am saying if the Commissioner

13

finds they were killed, we are in

14

this situation, are we not, that every

15

time the person was there killing a

16

baby, you were also there?

17

A. Right.

18

Q. So, you, more than any of

19

the other nurses on your team, had

20

the best opportunity to observe this

21

person and observe anything suspicious

22

just by the fact that you were always

23

there?

24

A. Right.

25

Q. But based on your present



1

2

"recollection, I take it that you can't
recall now having seen anything that
excites or excited in you a suspicion
about somebody else's behaviour?"

5

6

And the answer is:

7

"A. Not really, no."

8

I was bothered about that and it
intrigued me because it wasn't a "no", it was "Not
really, no." And I am wondering whether or not
at the present time whether you have some doubts
about whether you saw something that excited your
suspicion during that nine month period? Can you
tell us first of all is the answer correct that you
gave?

14

A. Yes.

15

Q. And was the fact that your
answered it "Not really, no." does that mean there
was a doubt in your mind about whether you did or
did not see anything suspicious?

18

19

A. Well, the only thing that I
remembered was after Kathy Coulson's evidence about
seeing the doctor taking the IV bag out. I remember
that but at the time I didn't think anything more
of it.

22

23

Q. Well, when was that and what

24

25



1

2

baby death are we talking about?

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. I can't remember the baby at all, I just remember the doctor. There was a high potassium level that had come back and after they had got the results from the potassium level and the child was pronounced dead this doctor had taken an IV bag down.

Q. All right, took it away and off the ward?

A. Yes.

Q. And you did not think about that I gather for some three and a half years, some three years until you heard about the evidence of Kathy Coulson?

A. Right.

Q. And if it struck you at the time as being unusual you forgot about it for three years and then were reminded by her evidence?

A. Yes.

Q. Now, aside from that, Mrs. Trayner, was there anything else that you saw that was suspicious or excited your suspicion at all?

A. No.

Q. Thank you. Now, I want to deal with what has been and may be euphemistically



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

described as being framed or being set up but you told Mr. Lamek and Mr. Hunt that in view of the close association between the series of baby deaths and your presence on the ward that the thought crossed your mind that you were being framed or set up or somehow implicated in the baby deaths. Do you remember giving that evidence to both of them?

A. Yes.

Q. And you told both of them under oath that you knew no one at the Hospital who would do that, is that right?

A. Yes.

Q. And I suggest to you that if it was someone trying to implicate you it would have to be someone that knew your schedule, knew what happened on the day to day activities in the Hospital, knew what happened by way of protocol involving nurses and doctors and the interaction, knew what occurred, very familiar with the activities of Ward 4A, if in fact you were being set up?

A. Right.

Q. It would have to be that?

A. Yes.

Q. Do I take it that that same individual would have to know when you were on long



1

2

night shifts?

3

A. Yes.

4

Q. Would have to know when you

5

were off?

6

A. Yes.

7

Q. Would have to know your

8

apartment address, know your car, know your bank,

9

know that you and your husband go to the Armoury

10

from time to time?

11

A. I suppose, yes.

12

Q. All of those things. I mean,

13

if we are to pay any importance to, we have called

14

them dirty tricks in this Commission, if we are

15

paid to pay any attention to that, that person would
have to intimately know you?

16

A. Yes.

17

Q. And I gather that it follows

18

does it not that if that person knows all of those
things that happened at the Hospital and knows all

19

about your personal things it would have to be

20

somebody that both has a function at the Hospital

21

of some sort and has to be close to you; if we are

22

looking at somebody that might be implicating you?

23

A. Yes.

24

Q. And I think you told Mr. Hunt

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

and Mr. Lamek that you first started thinking about that possibility even before the Atlanta Report came out?

A. Yes.

Q. And it was not during the preliminary hearing certainly back in February of 1982 that you were thinking about it it was even after that, was it not?

A. It was shortly after that.

Q. All right.

MR. THOMSON: Well, can she finish her answer?

MR. PERCIVAL: Q. I'm sorry, please do.

A. I just wanted to clarify it. It was suggested to me first by the police officers.

Q. I beg your pardon?

A. It was suggested first by the police officers.

Q. All right. Well, I suggest to you, Mrs. Trayner, that when you really started to think about whether or not somebody was trying to put you in a bad light was when you received a letter on September 19th, an anonymous typewritten letter, received it at your home address, 24 -- I'm sorry,



1

2

I won't read that into the record but it is a letter
that you received, an anonymous typewritten letter?

4

A. Yes.

5

Q. And I want to show it to you.

6

First of all, this is a photostat of both the
envelope and the anonymous letter. You received
that letter I suggest to you on or about September
20th, 1982. That's the post mark on it, the post
mark is the 19th but I presume you probably received
it shortly thereafter?

10

11

A. Yes.

12

Q. And you remember receiving

13

this letter?

14

A. Yes, I do.

15

Q. And when you opened the

16

envelope, and you did open the envelope yourself?

17

A. Yes.

18

Q. And it was delivered to your

apartment?

19

A. Yes.

20

Q. By mail?

21

A. Yes.

22

Q. And it came into your mail

box in the apartment?

23

A. Right.

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. So, when you received it you looked at the envelope and it had your proper address, it had your proper name and it had your proper postal code?

A. Right.

Q. All right. And then you opened the envelope and you read this letter. I want to read it correctly. It says:

"Dear Phyllis,

The police interviewed me a couple of weeks ago.

They showed me all the files and I went through them and told them what little I remembered like all the girls are doing.

But they kept up questioning me about you, over and over.

I couldn't keep it to myself anymore and I told them what I had suspected all along about what was happening.

I finally had to admit what I had seen you doing on at least 2 times.

I always admired you, but you need help, get it now.

I'm sorry I had to be the one to tell



1

2

"the police but it's over and off my
chest.....

3

4

For Gods sake Phyllis, get some help."

5

Do you recall receiving that letter?

6

A. Yes, I do.

7

Q. Would you tell the Commissioner,

8

because I want to be fair to you, you did, after a

9

short period of time, within the day I think, turn

10

this over to Mr. Strathy who promptly turned it over

11

to the police. But tell me what was your reaction

12

A. I was very shocked, very

13

upset. I phoned my husband at work.

14

Q. You were so shocked and so

15

upset you dropped the letter, didn't you?

16

A. Yes, I think I did.

17

Q. Because here was someone in

18

the course of this letter accusing you of being

19

implicated, being at blame, having done something

20

wrong to these babies?

A. Right.

21

Q. There was no doubt in your

22

mind that that is what it referred to?

23

A. Well, I thought that the --

24

Q. The babies I am talking about?

25



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

A. Well, the person that had written it spoke to the police and she was telling me this.

Q. All right. That's what the letter says?

A. Yes.

Q. And you were shocked by its contents, you phoned your husband immediately?

A. Yes.

Q. And then you eventually turned it over to Mr. Strathy who turned it over to the police, isn't that true?

A. Yes.

Q. Now, I suggest to you, Mrs. Trayner, was this not the first time that you thought that some person out there was trying to blame you for these deaths? Wasn't this the first time?

A. I believe so, yes.



26apr84
E
DMrc

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Because it was sent to your home address, or apartment, and your name "Phyllis Trayner" wasn't in the phone book at that time?

A. No, it was not.

Q. So that person would have to know your husband's first name or initials? It was under your husband's name, if I looked it up in the phone book. In 1982 was your name in there?

A. I don't think either of us were in the phone book.

Q. So somebody else had got the address from somewhere?

A. Yes.

Q. And it was the correct address?

A. Yes.

MR. PERCIVAL: I'm sorry, Mr. Commissioner, I haven't had that marked. Could I have that marked as the next exhibit, please?

MR. LAMEK: Does it not have the address on it?

MR. THOMSON: I don't think he needs to have the address on the envelope, sir.

MR. PERCIVAL: I understand, and that is why I stopped. I don't know how we can do it



1

E2

2

except perhaps we can black out the exhibit.

3

MR. THOMSON: Do you need the
envelope?

4

5

MR. PERCIVAL: Except it does show --
well, perhaps I can do it this way.

6

7

MR. LAMEK: I understand that is the
former address, so it may or may not be of great
significance any more, but I just raised the point.

8

9

MR. PERCIVAL: Perhaps I can ask
the witness.

10

11

Q. Mrs. Trayner, is this your
former address? You are now no longer living at
that address?

12

13

A. No, I am not.

14

MR. PERCIVAL: So it doesn't matter.

15

16

THE COMMISSIONER: There is no
problem.

17

18

19

20

21

MR. PERCIVAL: I am quite content
that the envelope not be part of the exhibit, Mr.
Commissioner, because, you know, I am as concerned as
Mr. Lamek is. As long as you are satisfied that the
date is 19th of September 1982 and the witness has
acknowledged that.

22

THE COMMISSIONER: Yes.

23

MR. PERCIVAL: There is no real

24

25



E3 2 purpose.

3 THE COMMISSIONER: It won't do any
4 harm, will it, to have the envelope, or will it?
5 Have you any problems about it?

6 MR. THOMSON: Could we discuss that
7 at the break, Mr. Commissioner?

8 THE COMMISSIONER: Yes. Well, all
9 right.

10 MR. PERCIVAL: We will leave that
11 in limbo perhaps.

12 THE COMMISSIONER: Yes. All right.
13 Anyway, it is going to be Exhibit 397, whether it is
14 just the letter or the letter and the envelope.

15 MR. PERCIVAL: Q. Now, Mrs. Trayner,
16 the letter says that --

17 THE COMMISSIONER: Wait a minute now.
18 I just see what is happening back here, that the
19 letter is being distributed to the press and the
20 envelope as well.

21 MR. THOMSON: I think it is not
22 right that the envelope be given until we resolve the
23 issue.

24 THE COMMISSIONER: No. I agree. I
25 think the press themselves would prefer not to have
it, if anything does happen.



E4

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MR. PERCIVAL: I agree with that,
Mr. Commissioner.

THE COMMISSIONER: So please don't
distribute it until this matter is resolved.

Yes.

MR. PERCIVAL: Q. In any event,
the letter says, Mrs. Trayner, as I read it:

"They showed me all the files and I
went through them and told them what
little I remembered, like all the
girls are doing..."

Now, did you take it from that,
the terminology, that the author of the letter was
female? Did you take it from that terminology?

A. Yes.

Q. And can you now think today,
or did you think in September of 1982, of anyone at
that Hospital, whether male or female, who would bear
such animosity to you that they would send in effect
a poison pen letter like that to you?

A. No, I couldn't.

Q. And you couldn't think of
one then and you can't think of one now?

A. No.

MR. PERCIVAL: May this be a convenient



E5

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

time, Mr. Commissioner, I am going to go to another area?

THE COMMISSIONER: Well --

MR. PERCIVAL: I will keep going.

THE COMMISSIONER: No, no. The problem is if we break off now that means we will break off again.

MR. PERCIVAL: No, I don't want you to do that, obviously. I will carry on.

THE COMMISSIONER: I think it is sensible if you would carry on until you fall down exhausted just before eleven o'clock.

MR. PERCIVAL: Fine. Thank you. I think that I will not.

Q. Now, I want to deal with another matter, Mrs. Trayner, that deals with the aspect of drug errors, and I think we alluded to this yesterday, or perhaps Mr. Hunt did. I gather you realized that now, as you have said even, that we are now over three years since the conclusion of the series of baby deaths, and you have been aware from time to time of what has been happening at this Commission, and you have read the contents of the Atlanta Report?

A. Yes.



E6

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. And you are aware of course that this Commission is entrusted with the obligation of finding out how and by what means any of these 36 babies, or the 29 babies, if we can talk about you, how they died and by what means they died? You understand that?

A. Yes.

Q. And I gather that there are three possible causes of death at least that spring to your mind. That would be like natural causes caused by some anatomical anomaly and complications that caused the babies' deaths on the ward?

A. Yes.

Q. The second one is a deliberate act that someone, such as administering a deliberate unauthorized dose of digoxin; that is the second possible cause?

A. It's a possible cause.

Q. All right. The third could be a negligent act by someone giving, not intentionally, not deliberately, giving some medication, and if the Commissioner finds that we are a looking at digoxin, it would have to be someone giving digoxin to these babies in a negligent or non-deliberate way?

A. Yes.



E7

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Is there any other possibility so far as the cause of death that springs to your mind at this stage, three years later, aside from those three possibilities?

A. No.

Q. I want to deal with the last possibility if I can. In the nine months that you were team leader on Ward 4A that we are concerned with, and in your association with 29 of those baby deaths, did you ever see any activity or event, anything out of the ordinary that caused you to believe that someone had done something wrong in relation to the medical care of these children; wrong in the sense of doing something inappropriate and not in accordance with good medical and nursing practice, so far as those 29 babies are concerned?

A. There was a concern on the floor about Sui Scott.

Q. Well were you ever aware of any occasion when she made a drug error that caused the death of any child on that ward?

A. No, I am not.

Q. And were you aware that - and I suggest to you that you are only aware of one occasion where there was a drug error and an incident



E8 1
2 report prepared involving the medication of digoxin
3 during the nine-month period; isn't that correct?

4 THE COMMISSIONER: I don't think --

5 MR. PERCIVAL: Well I understand
6 that was the occasion involving Susan Reaper and
7 Mary Jean Halpenny involving Inwood and Pacsai.

8 THE COMMISSIONER: There were three
9 incidents, were there not, in the fall?

10 MR. PERCIVAL: I want to know whether
11 she was aware of them.

12 Q. Were you aware of any one
13 other than the Pacsai/Inwood problem?

14 A. No, I can't recall specifically.
15 Just that I know Kevin Pacsai and Kristin Inwood.

16 Q. That is one that you were
17 certainly aware of because it occurred when you were
18 there?

19 A. Yes.

20 Q. Are you aware of any others
21 in that nine-month period that involved digoxin,
22 either given to the wrong child or given in an
23 unauthorized dosage or not given when it should have
24 been; any of those possibilities, anything else
25 aside from the Pacsai/Inwood situation?

A. I know digoxin was given at



1

E9

2

nine o'clock when it had already been given at 5:30.

3

Q. Anything other than that?

4

Did that happen on one occasion or more than one occasion?

5

6

A. There were a couple of occasions it happened.

7

Q. Those babies did not die?

8

A. No.

9

Q. Anything else?

10

A. I don't believe so.

11

12

13

14

15

16

17

Q. Based upon then your own knowledge of what transpired in that nine-month period, I suggest if the Commissioner finds that 6, 8, 10, 15 of these babies died from overdoses of digoxin, I gather we can exclude on the balance of probabilities that they were caused by an unbelievable continuing series of medication errors in this Hospital?

18

A. Yes.

19

20

Q. That is not a logical or probable opinion that you have at this stage?

21

A. I don't know. I am not really qualified to --

22

23

24

25

Q. You didn't believe it then and I gather you don't believe it now, that all of



E10

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

this was caused by drug errors, do you?

A. Well it is a possibility.

Q. Well, possibilities range from half a million per cent upwards. Are we talking about a very, very slight possibility, ma'am?

A. Yes.

Q. Thank you. I want to deal with the death now of Baby Pacsai.

Kevin Pacsai, according to Exhibit 383, was a baby that died in Intensive Care, although the distress and the terminal events commenced while you were on long night shift on 4B on March 12th, and the baby died at ten o'clock the morning after you finished your shift in the ICU. You understood that?

A. Yes.

Q. I understand, and I am trying to -- I understand from your evidence, and I want to be clear on this, that at some point in time following that baby's death on March 12th, you became aware of the involvement of the Coroner.

A. You mean that night?

Q. No, at some time after that, you became aware of the involvement of the Coroner?

A. Yes.



E11

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. And we know, and you have already told us that Susan Nelles talked about, on March 20th, Friday, March 20th, about being called while she was on holidays by Liz Radojewski and being told about the Coroner and doing something about notes.

A. Yes.

Q. You have told us about that but I want to know, prior to March 20th, how much prior to March 20th did you become first aware of the Coroner's involvement involving the death of Kevin Pacsai?

A. It wasn't until that Friday night that Susan Nelles had told me, March 20th?

Q. Maybe I am wrong, that you have told Mr. Lamek at Volume 130, page 399, that you heard about it shortly after March 12th but you didn't hear about the actual reading, the 25 reading, until March 20th, when Susan Nelles told you.

Now perhaps I will refresh your recollection with the evidence. This is when you were being questioned by Mr. Lamek at page 399:

"Q. Did you subsequently learn Kevin Pacsai, at the time of his death, had an elevated serum digoxin concentration?



Trayner
cr.ex. (Percival)

E12

1

2

A. Yes.

3

Q. When did you learn that?

4

A. I can't remember if it was
that night that Dr. Schaffer was
on the floor.

6

7

Q. That night being the 12th of
March?

8

A. Yes. Or shortly after that.

9

10

Q. All right. Do you know from
whom you learned it?

11

12

13

14

15

A. Dr. Schaffer was on the floor
and we had asked him what had
happened to Pacsai and he was ex-
plaining events, that Baby Pacsai's
father was extremely upset and very
angry.

16

Q. Yes.

17

18

19

20

A. He explained that they had
taken a blood sample of the electro-
lytes and everything and the dig.
level was elevated.

And carrying on, the bottom:

21

22

23

24

25

Q. Did he also tell you what the
results of the digoxin assay were
on those samples?



E13

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. He just told me that they were elevated."

I am sorry, and you are probably right, I misunderstood your previous evidence. So, do I take it, at least in 402 you seem to say that in relation to the digoxin level being advised by Susan Nelles - is it the Friday, March 20th before you started the shift involving Baby Miller that you first learned both of the 25 level as well as the involvement of the Coroner?

A. It would be shortly after report, so it would be quarter to eight or eight o'clock that night.

Q. Again that is the first time you knew of anything involving the Coroner's investigation into the death of Kevin Pacsai, at the beginning of the long night shift on Friday, March 20th, the night that Baby Miller died?

A. Yes.

Q. Can I ask you first of all, and I think you were already asked this, but never before up until March of 1981 had you ever been involved with a Coroner investigating a death in a hospital?

A. No, I hadn't.



E14

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. And did you know what that involved?

A. Not really.

Q. I mean, had somebody told you in the course of orientation or whatever, or nursing school, or acting as team leader course, were you ever made aware what a Coroner did or did not do involving this?

A. No.

Q. And Mr. Lamek correctly points out that you did complete on each of the 29 baby deaths, or many of them in any event, a check list, a Death Check List, that very much pointed you to Coroners, but I gather you never read that?

A. That's right.

Q. So do I take it that on the night of March 20th, when you found out that the Coroner was involved, you also knew there was going to be an inquest?

A. Yes.

Q. Had you ever attended an inquest before?

A. No, I hadn't.

Q. Did you know what an inquest was?



E15

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. I knew that it was a hearing
and I knew that it was held in a courtroom.

Q. Well not eight months
before, seven or eight months before, there had been
about a week-long Coroner's inquest involving The
Hospital for Sick Children involving an eight-year-old
boy by the name of Stephen Yuz. Were you aware of
that in March?

A. I was aware of that case, yes.

Q. You were aware that there was
in fact a Coroner's inquest and a jury making certain
findings in the month of May 1980?

A. Yes.



F
EMT/cr

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Shortly before this nine month period commenced?

A. I believe so, yes.

Q. And you were aware then that nurses and doctors were called and were required to give evidence under oath before a coroner?

A. Yes.

Q. So to that extent you had some knowledge about what a Coroner's Inquest involved?

A. Yes.

Q. Thank you. And did you know of any other inquest again as a result of your relationship with the Hospital for Sick Children; did you know anything more about an inquest other than what you have said?

A. No, I don't.

Q. And when Susan Nelles told you that particular night about the head nurse's request that she prepare notes about the death of Kevin Pacsai, did you wonder to yourself why you might not have been asked to prepare notes as well since you were on the ward?

A. No. It was Susan's patient.

Q. All right. So do I take it then even though that request had been made by the



1
2 head nurse to Susan Nelles you didn't feel that you
3 had to worry about preparing notes or try to refresh
4 your recollection or the fact that you would even be
5 a witness at the Coroner's Inquest involving Kevin
6 Pacsai?

7 A. That is right.

8 Q. And do I take it that even
9 then on March 20th you didn't feel that you really
10 had to worry about what happened to Kevin Pacsai
11 save and except that you were somewhat surprised by
12 the very high digoxin level that was reported to you?

13 A. I would be - it was just a
14 member of my nursing team --

15 Q. All right.

16 A. - that would have to appear.

17 Q. And that was important to you?

18 A. Yes.

19 Q. Because you had worked together
20 for nine months and you told Mr. Hunt and Mr. Lamek
21 that your team was your team; something that you were
22 close after nine months of working?

23 A. Yes.

24 Q. Because it involved her, it
25 directly involved you I gather?

A. Not directly. I think I just



1
2 would have felt for Susan.

3
4 Q. All right. Do I take it that
5 then that night if we can talk in terms of when Baby
6 Allana Miller was on the ward on March 20th, when
7 Susan Nelles told you about this you knew there was
8 a problem about digoxin even though the doctors, and
9 I think you said was it David Nelles said that must
be an error, a mathematical error; it wasn't 225;
it was 2.5?

10 A. Well, it was David Nelles and
11 Dr. Paul Runge that were up --

12 Q. They just happened to be -
13 again were they visiting the ward that night?

14 A. Yes, they weren't assigned to
15 the floor.

16 Q. All right. So again - and
17 they were both residents?

18 A. Yes.

19 Q. And they said, gee, that's a
20 high reading but maybe it's a mathematical error.
21 Is that what you recall?

22 A. Yes.

23 Q. Did you think it was a
24 mathematical error?

25 A. I had never heard of a level



F
EMT/cr

4

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

that high, and we had heard from a couple of doctors other than Dr. Nelles and Dr. Runge that, no, it couldn't have been that high. It had to be 2.5.

Q. What other doctors? When was that?

A. That was when Michael Schaffer came back on the floor that night.

Q. Or was it the next night when Justin Cook ...

A. It must be the next night.

Q. I want to deal with your state of mind then when you found out about the Coroner's Inquest.

In any event you had doctors saying it is a mathematical error but you knew that one member of your team was being requested to take notes, prepare notes about what she did and what she didn't do about giving digoxin to Kevin Pacsai, and you knew there was a forthcoming Coroner's Inquest?

A. That is right.

Q. And do I take it from that, from all of that, whether it was a mathematical error or otherwise, there was a certain degree of, if I can use the expression, an heightened awareness of medication problems involving digoxin on your wards



5
1
2 4A and 4B.

3 In other words, you were now thinking
4 in terms of digoxin and making sure there was not
5 going to be any mistakes?

6 A. No, I don't know if that was
7 really a very conscious effort at all. We always
8 checked digoxin --

9 Q. Well.

10 A. - and it just continued on.

11 Q. Susan Nelles that night when
12 she told you about the forthcoming Coroner's Inquest,
13 did she seem anxious about it or was she looking
14 forward to giving evidence?

15 A. I remember Susan just being
16 upset that Liz Radojewski had called her at home.

17 Q. I am not talking about how she
18 was advised; I am talking about what she believed was
19 going to happen in the future. Was she anxious about
20 having to give evidence, being called in to question
21 about the death of Kevin Pacsai or was she unconcerned?
22 That is what I am asking about, about the forthcoming
23 inquest.

24 A. She was anxious that they check
25 out McMaster Hospital as well.

Q. Well, do I take it that she was



1
2 anxious in the sense that she felt somewhat
3 threatened by the fact that she was going to have
4 to give evidence at the Pacsai inquest and that she
5 wanted to make sure that they checked out McMaster
6 as well because that may be where it happened?

7 A. She knew what she had done that
8 night. She had written down her notes, but she was
9 concerned that they check out McMaster from where the
10 baby came from.

11 Q. All right. When you say she
12 knew, did she tell you again what she had done that
13 night?

14 A. She told me that Liz Radojewski
15 had told her to write down the notes.

16 Q. I know that, but did you say,
17 well, listen, what did you do?

18 A. No, I didn't ask her that.

19 Q. And she didn't volunteer what
20 she had done?

21 A. No.

22 Q. Did she tell you she had
23 written out the notes?

24 A. Yes.

25 Q. Now that night Allana Miller
was under the initial care of Susan Nelles, and that



Trayner, cr.ex.
(Percival)

1

2

baby was in Room 423?

3

A. Right.

4

Q. Again the same single cot
room that we have discussed involving Janice Estrella?

5

A. Yes.

6

7

8

9

10

11

Q. I note if I look at the chart
involving Allana Miller that Allana Miller two hours
after (that is Exhibit No. 115, Mr. Commissioner) was
prescribed digoxin and in fact Susan Nelles is
reported to have given digoxin to Baby Allana Miller
at 9 o'clock.

12

A. Yes.

13

14

15

Q. All right. And that would be
approximately an hour and a half, an hour and three-
quarters after you reported on shift on the night
of Friday, March 20th?

16

A. Right.

17

18

19

20

Q. And that was after you had
discussed the Kevin Pacsai forthcoming inquest and
after you had learned of the sort of, I suggest to
you, a rather shocking number as being the digoxin
level in that baby at its death.

21

A. Yes.

22

23

24

25

Q. And do you remember having
that background behind you going with Susan Nelles



1
2 and checking out the digoxin before it was administered
3 to Allana Miller? You as team leader.

4 A. No, I don't.

5 Q. Do you remember - did you
6 remember whether or not you checked it out with Susan
7 Nelles that night?

8 A. I can't specifically recall
9 that, no.

10 Q. So do I take it if you did
11 nobody paid very much - there was nothing said about,
12 well, gee, we had better be double sure tonight about
13 the digoxin because of Kevin Pacsai and because of
14 the forthcoming inquest? You don't recall anything
15 of that?

16 A. No.

17 Q. So if in fact there was an
18 awareness of the forthcoming Pacsai inquest, the
19 high digoxin level, nothing happened at 9 o'clock
20 when that digoxin was drawn up for Allana Miller by
21 Susan Nelles, and you can't even remember checking
22 it with her?

23 A. That's right.

24 Q. All right. Do you recall
25 whether you were present when Susan Nelles gave this
digoxin to this child Allana Miller at 9 o'clock?



1

2

A. No, I wasn't there.

3

Q. That particular night, and

4

by 9 o'clock do you remember whether you had been
assigned as team leader to any particular child?

5

A. I had a baby in 418 that I

6

was taking care of.

7

Q. 418 - sorry?

8

A. I was taking care of a baby

9

in 418.

10

Q. All right. That baby, Allana

11

Miller, do you recall having seen that baby Allana

12

Miller prior to 9:00 p.m. that first shift of Friday,
March 20th?

13

A. I don't have any specific

14

recollection of it, no.

15

Q. Maybe I could deal with

16

something that I am perhaps ignorant about, but that

17

baby had some sort of monitor on it that night?

18

A. Yes.

19

Q. And what kind of monitor was

20

that?

A. A cardiac monitor.

21

Q. All right. And the cardiac

22

monitor, does it have settings?

23

A. Yes.

24

25



1

2

Q. And the settings, what does
the cardiac monitor monitor? What does it do?

3

4

A. The heart rate.

5

Q. The heart rate?

6

A. Yes.

7

Q. Is that also known as the
pulse?

8

A. The apical rate, yes.

9

Q. The apical rate. And I suppose
if one looked at the monitor and it had a reading of,
say, 78, if one took the pulse of the child at the
same time you would get about 78?

10

11

12

A. That's with the ideal, yes.

13

14

Q. So when the cardiac monitor
was on Allana Miller that you can recall that night,
and I want to know and you will be happy to know that
I don't intend to go into the rather extensive
evidence involving the apparent conflict between
you and Bertha Bell with respect to what was observed
then, but I want to go into some other matters that
perhaps are in addition to that.

15

16

17

18

19

20

21

22

23

24

25

I want to talk in terms of matters
involving first of all the lighting that was in
Room 423 that night, and secondly to deal with the
question of where the furniture and the IV was



11

1

2

located.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

We haven't talked in terms of lighting, and do I take it that your recollection is that that night around midnight of March 20th when Allana Miller was in Room 423 and Susan Nelles was involved in looking after Justin Cook, that there were lights on in Room 423?

A. There was the overhead light on.

Q. Was it a well lit room at that time?

A. I believe so, yes.

Q. And perhaps -- do you have difficulty remembering whether it was well lit or otherwise because I will refer you to your other evidence.

A. I would appreciate that.

Q. All right. It is page 680, and that is in Volume 3, Mr. Commissioner, and you were being questioned by Mr. McGee at that point:

"Q. In Allana Miller's room that night what was it like as far as lighting goes? Was it bright or was it dull or what?

A. It was a well lit room.



12

1

2

"Q. It was well lit?

3

A. Yes, it is.

4

Q. Are the lights changed in any way when the babies go to sleep?

5

A. We try and dim them but 423 has its own bathroom.

7

Q. Yes.

8

A. So what we did was turned off the big overhead light, turned on the bathroom light and left the bathroom door opened a bit, took the overhead light down and put it to the side and turn that on so it wasn't shining in the baby's face.

10

11

12

13

14

Q. Was it the normal lighting in the room that night?

15

16

A. There was normal lighting.

17

We turned off the overhead light.

18

Q. Yes. So it wasn't the normal lighting?

19

20

A. No, but we don't use normal lights at night. We try to let the children sleep.

21

22

Q. No, it wasn't the lighting as it would be during the day?

23

24

25



13

1

2

"A. No."

3

Now does that refresh your recollection,

4

Mrs. Trayner?

5

A. Yes.

6

Q. I want to know, though, given

7

the lighting as you have described it, do I take it

8

that there were no shadows in the room? If I came

9

to the doorway would you see shadows? There would

10

be light coming from the bathroom and the light that

11

was turned from the side of the baby's bed? Would

12

you see any shadows?

13

A. I have never thought about

it.

14

Q. Well, I want you to think

15

about it now if you would. Do you recall there being

16

any shadows in that room or any problem seeing in

17

that room that night as you attended Allana Miller?

18

A. Well, there was no problem

seeing her.

19

Q. All right. Was the baby

20

plainly visible from the doorway?

21

A. I believe so, yes.

22

Q. All right. Would the IV and

23

the monitor be plainly visible from the doorway?

24

25



1

2

A. Yes.

3

Q. And there would be no curtains

4

or pieces of furniture blocking the view of anyone
from the doorway?

5

A. I don't think so.

6

Q. Now your evidence to Mr.

7

Lamek, and this is found at Volume 133, page 616, as

8

to where the IV pole was located, and as I understand

9

your evidence is that the baby in 423 had a cot that

10

was over near the window?

11

A. Yes.

12

Q. And the cot ran parallel to

the window?

13

A. Yes.

14

Q. And that the IV pole and the

15

night table was located between the bed or cot and

16

the doorway?

17

A. Yes.

18

Q. Is that your evidence to Mr.

Lamek?

19

A. Yes.

20

Q. And I think at 617 and 618,

21

and if I may read it to refresh your recollection,

22

your evidence before this Commission is as follows.

23

And this is at the time you were flushing Allana

24

25



Trayner, cr.ex.
(Percival)

1

2

Miller's IV at about midnight:

3

"Q. Can you tell me how you flushed
Allana Miller's IV at about midnight?

4

5

A. I released some fluid from the
IV bag, from the little clamp that was
up there and filled up the buretrol to
the amount of fluid that I had wanted;
turned off the clamp and I may have
increased the IV flow, I am not sure.

6

7

8

9

10

Q. Now, Mrs. Trayner, as you were
doing that, you are doing something
that the reporter can't record. Do
I put it fairly that as you have

11

12

13

14

15

16

17

described what you did you were holding
your right hand up approximately level
with the top of your head to indicate
with that hand you were releasing fluid
from the IV bag?

18

A. Right.

19

20

21

Q. And at the same time you were
holding your left hand out at about
chest height, and I take it you were
what, holding the buretrol?

22

23

A. Holding the buretrol so that
I could see the numbers.

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

"Q. All right. And if I may say so
you made those gestures in the way
that one would make them if one were
accustomed to doing them over and over
again. Is that the way you normally
flush an IV?

A. Right.

Q. Have you ever to your
recollection flushed an IV with the use
of a syringe?

A. No, not for the purpose of an
IV medication, no."

- - - -



BM/ak

1
2
3 And then I think that you were asked -
4 do you recall telling Mr. -- I see, perhaps I missed
5 on that. Do you recall telling Mr. Lamek as to
6 where you were when you flushed the IV bag and I
7 think at the bottom of 616 you said:

8 "Q. So I take it then in going to
9 the IV to flush it you were standing
10 on the door side of Allana Miller's
11 bed?

12 A. Right.

13 Q. You were between the bed and
14 the door?

15 A. Right. Or beside the bed."

16 Is that your recollection as to what
17 you did at midnight on March 20th, 21st at Allana
18 Miller's room, 423?

19 A. Yes.

20 Q. And where you were standing
21 when you did that?

22 A. Yes.

23 Q. Are you aware of the evidence
24 of Bertha Bell as to where you were when she saw you
25 giving what she described as a medication into the
buretrol with the 3 cc syringe? Are you aware of
her evidence?



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

A. I don't know, I'm aware that she said that she saw me giving this medication.

Q. All right. Well, have you read her evidence before you gave evidence here today?

A. No, I haven't.

Q. You have never read Mrs. Bell's evidence on this rather crucial issue as to whether or not you were giving medication at 12:00 midnight or merely flushing the IV line?

A. I have read summaries but not Mrs. Bell's evidence per se from the Commission.

Q. Well, do you remember what, based on those summaries, her evidence was as to where you were located when she saw you giving that medication?

A. At an IV pole?

Q. Yes, but do you recall anything more than that, that you were at the IV pole injecting medication with the 3 cc syringe as to where you were located in the room? Do you remember reading that?

A. No, I don't.

Q. Well, because I will refresh your recollection, at Volume 102, 3237, the bottom



1
2 of the page. This is Bertha Bell being examined by
3 Miss Cronk:

4 "Q. You have also told us that
5 when you saw Phyllis Trayner giving
6 that medication, or administering
7 that medication into the buretrol,
8 you spoke to her?

9 A. Yes, I believe I did.

10 Q. And you told me during your
11 prior evidence that she knew you were
12 in the room?

13 A. Yes.

14 Q. Do you have a clear recollection
15 in your mind today, Ms. Bell, that
16 Phyllis Trayner and you spoke on that
17 occasion of when you saw her administer
18 that medication?

19 A. I recall her being on the other
20 side of the cot, so that she would see
21 me coming in, she would be facing -
22 like I saw her, I can recall her putting
23 up her arm and putting it into the
24 buretrol, so she would be half facing
25 me as well.

Q. Do you have a clear understanding



1

2

"today that Phyllis Trayner knew you
were in the room?

3

4

A. I believe she knew, yes."

5

6

Do you recall, after me having read
that to you, that that was her evidence in fact
that when she saw you giving that medication that
you were on the other side of the cot as opposed to
between the doorway and the cot?

7

8

9

A. I didn't read that.

10

11

Q. So, do I take it that this is
the first time you are aware of her evidence?

12

A. Yes.

13

THE COMMISSIONER: Any time you want.

14

MR. PERCIVAL: I am very thirsty
of coffee right now, Mr. Commissioner.

15

16

THE COMMISSIONER: All right, we
will take 20 minutes.

17

--- Short recess.

18

--- Upon resuming.

19

THE COMMISSIONER: What is the story
on our exhibit now, Mr. Strathy?

20

21

MR. STRATHY: We don't have any
concern, Mr. Commissioner, with the entire exhibit
including the envelope going in.

22

23

THE COMMISSIONER: Okay.

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MR. PERCIVAL: Fine, thank you,
Mr. Commissioner. Both pages of the document will
be marked as the next exhibit?

THE COMMISSIONER: Both pages will
be marked and that will be Exhibit 397.

---EXHIBIT NO. 397: Anonymous letter to Phyllis
Trayner with attached envelope.

MR. PERCIVAL: Q. Mrs. Trayner,
I want to deal with a matter that has to do with
what transpired when you decided to give the gentamicin
to Baby Allana Miller and when you went to the room
where Justin Cook was being looked after by Susan
Nelles and showed her certain things, a syringe I
think.

A. Yes.

Q. And you were questioned by
Mr. Lamek about this at Volume 134, page 816 to 820.
Mr. Lamek questioned you about this and pointed
out to you, and you seemed to agree with him, that
both the purposes for showing this particular
medication to Nurse Nelles were basically unsuccessful
because of the manner in which you did it, and I think
you agreed with that.

A. Well, the objective was not to



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

have the drug repeated.

Q. All right. Do I take it that the Pacsai inquest was certainly in your mind, although it may not have been the primary reason why you showed it, in other words, while you were mindful of the forthcoming Pacsai inquest and the concern about giving appropriate medication, that was not your prime purpose?

A. That's right.

Q. Your prime purpose was to make sure that she knew that you had given it and that she would not duplicate it and that the correct medication and dosage would be given to the child?

A. Right.

Q. All right. And I think that you used the expression on one occasion, you wanted to be a bit more careful.

A. Yes.

Q. All right. Do I take it that the reason for showing the medication to Nurse Nelles in the room before administering it to Allana Miller was that there would be no mistake, such that it would be given to the right child, given at the right time, given in the right dosage and the right medication would be given to the right child; for



1

2

all those reasons, those are the types of mistakes
that can occur?

4

A. Yes.

5

Q. And all of these are important?

6

A. Yes.

7

8

9

10

And I gather based upon your
evidence that is equally important I suggest to you
so that it will not be duplicated, it will not be
forgotten about, is to properly sign off the medica-
tion that you administered?

11

A. Yes.

12

13

14

Q. And you didn't and you frankly
admitted in these proceedings that you did not
sign off that medication but Susan Nelles did?

15

A. Yes, she did.

16

17

18

Q. My recollection is that you
in fact collaborated with Susan Nelles in the
preparation of the final notes following the death
of Baby Allana Miller?

19

A. Yes.

20

21

22

23

24

25

Q. Because the reason that you
had to collaborate I suggest to you is the fact that
she was not with the child from about 10:30 when
Justin Cook came on the ward until about 2 o'clock
when she resumed looking after Baby Miller and



1

2

certain unfortunate events transpired with respect
to that baby?

4

A. Yes, she was in there

5

occasionally.

6

Q. All right. But she wasn't

7

looking after the child, she was preoccupied - not
preoccupied, but she was supposedly and totally

8

looking after Justin Cook and the rest of the

9

members of the team were trying to take on her

10

other roles.

11

A. Yes.

12

Q. Is that fair?

13

A. Yes.

14

Q. Now, you were questioned on

15

this at the preliminary hearing as to why, given

16

those circumstances, you didn't sign off this

17

medication involving the gentamicin that you had

18

You were talking about gentamicin,

19

and this is in examination by Mr. McGee:

20

"The next dose was given again at 9:00

21

a.m. by Susan Fitzgerald, was given

22

again at 6:00 p.m. by Susan Fitzgerald

23

and on the 21st of the 3rd at 1 o'clock

24

Susan Nelles signed for it.

25



1

2

"MR. McGEE: She signed for it but --

3

A. I gave it.

4

Q. You gave it but she signed for
it. Is that standard procedure?

5

6

A. No, it's not legal or it's
not proper.

7

8

Q. Do you know why it was done in
that way and in this case?

9

10

A. I don't know, I forgot to sign
it, when the child arrested I never

11

really got back to the chart to sign

12

it off but I did give the medication."

13

Now, do you recall being asked those
questions and giving those answers?

14

A. Yes.

15

16

Q. Well, what concerns me is,

17

you said "I never really got back to the chart to
sign it". The child didn't die until something

18

around 3 o'clock and there was another four hours

19

of that long night shift that was available to you

20

should you wish to do it to sign the chart, to sign
the medication off.

21

A. Yes.

22

Q. Isn't that right?

23

A. Yes.

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. And you collaborated with Susan Nelles in putting her final nursing notes, so, I gather the chart was available to both you and Susan Nelles when you collaborated?

A. It would have been there.

Q. All right. So, do I take it that it wasn't a question that the chart was not available to you, it's just that you forgot about it?

A. Yes.

Q. And the next question and answer intrigues me and I just wanted to know what you meant by it:

"Q. Did you ever, did you discuss the entry with Susan at any time?

A. No, I think we weren't even worried about that, that was the least of the problems but my signature should be there."

What were you worried about at that point? The baby had already arrested and died, what was the least of your problems and what were the problems that you contemplated with that answer?

A. It was preparing or it was giving Susan Nelles the notes as to what had happened so that she could write the nursing note. There



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

G11

was cleaning up of the room, getting ready for the parents to come to see the baby and there were other things that I had to do for the night.

Q. But Mrs. Trayner, that is at 3 o'clock, you have four hours to go on the shift and it's not something new that has occurred with your team, you know, this is the 28th baby that has been unsuccessfully resuscitated by your team. It's not something new. But what was the problem, what was the problem to you that prevented you from signing it off properly, I don't understand. Those are not new problems, you've had them for 28 previous times, what was the new problem that was confronting you on that day?

A. There wasn't any problem, I forgot to sign off the medication.

Q. Well, do I take it it is really not defensible that you and Susan did what you did involving her signing for a medication that you gave? There is no real reason for that?

A. No, there isn't.

Q. All right. Now, Allana Miller on that shift, and I'm going back to it, but she wasn't on constant care, she wasn't on shared care.

A. Right.



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. And she was alone in Room 423.

A. Right.

Q. She was on a cardiac monitor, that you have told us, and I gather if I look at the flow sheet and perhaps we can give it to the witness. Do you have the flow sheet involving -- these are 35 and 36 at least on what I have before me, Mrs. Trayner, perhaps you could turn to that and look at them. It appears that whoever completed this, the flow sheets starting on your shift at the bottom of page 35 and at the top of 36 it would appear that even for the whole day of Friday, March 20th it was customary for the nurses to record vital signs every one hour; it seems to be.

A. On this child, yes.

Q. Yes, all right. What I want to know is this. The vital signs, and I want to put it to the side if I may the intake and output but the vital signs are the ones that are taken hourly, in this case at least, seem to be temperature, pulse, respiration and blood pressure.

A. Hourly you mean?

Q. No, I'm saying that those are the things, and I know you are going to say to me temperature is probably not taken hourly but



1

2

certainly pulse and respiration seem to be recorded hourly.

3

4

A. Yes.

5

Q. By and large?

6

A. Yes.

7

Q. With some exceptions, all right.

8

What I want to know is this. She was on a cardiac monitor. Would the pulse rate shown there, would that be from the cardiac monitor?

9

10

A. Yes.

11

Q. In other words, would you as

12

a nurse come in and look at the cardiac monitor

13

and if it said 78 then you would record it as 78?

14

A. No.

15

Q. I'm sorry. Well then, what would you do?

16

A. We listen to the child's heart rate.

17

18

Q. All right. But I understand

19

that, but when you get to the question of getting

20

the number, you take it from the monitor?

21

A. No, we count it.

22

Q. All right. You count it.

23

So, it is not something that you rely upon the monitor to record, it is something that you

24

25

G13



1

2

actually do?

3

A. Yes.

4

Q. All right. And you count it

5

by what, by a stethoscope?

6

A. With a stethoscope.

7

Q. All right, and with your

8

watch?

9

A. Yes.

10

Q. All right. Now, the cardiac

monitor is set high and a low is it not usually?

11

A. Yes.

12

Q. And the monitor buzzes or

13

goes off or alarms or something like that if the

14

heart rate goes beyond the level set or goes below
the level set?

15

A. Right.

16

Q. So, the buzzer can come on

17

for two reasons?

18

A. Yes.

19

20

21

22

23

24

25



H/DM/LN

1

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. On the question of irregularity and it is marked "iii" what does that mean? Does that mean that perhaps as far as the person making the observation is saying, on the monitor it looks like it is going up and down and up and down, and even with the stethoscope the heart starts to beat faster and then slower, is that what is meant by irregular?

A. It is irregular when we listen to it.

Q. So in other words in the course of listening to it over the course of a minute, the heart beats faster and then beats slower, and then it beats faster again, is that what is irregular?

A. That could be an irregularity, yes.

Q. What other irregularity is there on that?

A. There could be a coupling beat.

Q. Anything else, anything else --

A. There could be pauses.

Q. All of those three things might be irregularities that would justify the nurse recording an "i" or an "ir" on the pulse on the flow sheet.

A. Yes.



H1

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Thank you. Dealing with the temperature, I gather that is done so far as young babies are concerned with an anal thermometer?

A. A rectal thermometer, yes.

Q. Insofar as the respiration is concerned, is that something that is done by the nurse?

A. Yes. You can place your hand over the child's chest and count.

Q. And in relation to the blood pressure, how is that done on young babies?

A. There is a blood pressure machine and a cuff that you place on the child's arm.

Q. Which of those insofar as those four vital signs are concerned, temperature, pulse, respiration and blood pressure, can all of those be done when the child is awake or asleep?

A. You can do the heart rate and the respiration while they are sleeping.

Q. The blood pressure is probably going to wake them up if they are asleep.

A. It makes a lot of noise, it might wake them up.

Q. And the rectal thermometer would probably wake them up as well?



H3

1

2

A. It could, yes.

3

4

5

6

7

8

9

10

11

12

Q. One of the things that I have been concerned about, and we are going to get to that shortly, with Allana Miller, is when the monitor goes off, and that expression is used from time to time, when the monitor buzzes, what is a nurse supposed to do when the monitor buzzes when she goes into the room?

13

14

15

16

17

18

19

20

21

22

23

24

25

A. You can either look at the monitor and see what has happened, is it on a high or a low and you would listen to the child's heart rate and turn the buzzer off.

Q. So that is what a nurse does?

A. Yes.

Q. Does the nurse do anything else, aside from going in there, turning the buzzer off and then checking the heart rate herself?

A. She would check to make sure all the leads are on the child, that the machine is working properly.

Q. Well what happens - do I take it it is usually set on the low because you are worried about the baby's heart stopping and an arrest occurring and that is what the warning is for?

A. No, we have a range of a high and



H4

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

a low. Depending on the child's heart rate; if I can give an example, if the heart rate is usually 100 then we could set it down for 80 on the low side and we could set it for 140 on the high side. If it goes below those two numbers that I have just told you then the alarm would go off.

Q. Do I take it that it is done for the purposes of really warning the nurses of any changes in the usual or expected heart rate of the child in question?

A. Yes.

Q. And if something unusual occurred if a nurse went in and turned the monitor off and found that something - in other words that the heart rate was very very low and irregular, or very very high and irregular, that she would do something more than merely turn the monitor off, she would get a doctor?

A. Yes.

Q. Now from 7:15 to about 10:30 we have heard that Allana Miller was being looked after by Susan Nelles, and she had Allana Miller and I think the assignment sheets, she had one or two other babies, is that your recollection?



H5

1

2

A. Yes.

3

Q. And then Justin Cook and his

4

parents came onto the ward that you can recall,

5

shortly after 10:00 o'clock, and I think it was

6

closer to 10:30.

7

A. That's right.

8

Q. And Susan Nelles then took over

9

the admission of Justin Cook. I think you told us

10

that you saw the electrocardiogram being done and

11

then you saw her going off with a physician to the

echo cardiogram room to have the echo done?

12

A. Yes.

13

Q. So do I take it that for the

14

time period from about 10:30 until 1:45 or 2:00

15

o'clock, Susan Nelles was basically fully and totally

involved with the admission of Justin Cook?

16

A. She was busy with Justin Cook,

17

yes.

18

Q. That was a very sick baby then?

19

A. Yes.

20

Q. Probably the sickest baby on the

21

ward at that time because of the unusual procedure

22

that was used in having the parents come directly up

without even going through admitting?

23

A. Well, yes, it was.

24

25



H6

1
2 Q. And so during that time period
3 when Susan Nelles was preoccupied with Justin Cook,
4 what was happening to Allana Miller, who was
5 assigned to the care of Allana Miller in that time
6 period? You were the team leader and I gather you
7 had to change because you knew that Janet Brownless
8 was coming back down at 11:00 and that was preplanned,
9 but who was starting to look after Allana Miller and
10 who was responsible for Allana Miller during that
11 time period in question, from 10:30 until about 2:00
12 o'clock?

13 A. There were nurses on the floor,
14 there was no specific reason to be in the room with
15 Allana Miller, we were all available on the floor
16 if there was anything wrong.

17 Q. I understand that, but someone
18 at least had decided that all the vital signs were
19 to be taken and you as team leader did you not say
20 "well I guess I will be responsible for recording the
21 vital signs", or "you Nurse X will be responsible for
22 doing the vital signs", or "we will all do it
23 together". How do you know that somebody is going
24 to do it if you don't delegate it as a team leader
25 should do?

26 A. Well I did delegate.



H7

1

2

Q. Who did you delegate it to?

3

A. I asked Janet Brownless to do

4

her vital signs for Susan Nelles, when she returned

5

to the floor at 11:30. I told Susan that I would

6

check her IV and do the vital signs.

7

Q. Then if we look at the bottom

8

of page 35, is the handwriting for the 10:00

9

o'clock vital signs, temperature, pulse, respirations

10

and blood pressure is that your handwriting, or is
it Susan Nelles'.

11

A. The bottom of 35?

12

Q. At the bottom of page 35, the

13

third line from the bottom, 10:00 o'clock.

14

A. And it has just got the heart

15

rate and respirations?

16

Q. I'm sorry, 8:00 o'clock, you are

17

quite right Mr. Thomson, I'm sorry. 8:00 o'clock,
is that Susan Nelles.

18

A. Yes.

19

Q. At 9:00 o'clock, 2100 hours.

20

A. Susan's.

21

Q. At 10:00 o'clock, the very bottom.

22

A. Susan.

23

Q. Now we know that she became

24

involved with Justin Cook at about 10:30 according

25



H8

1

2

to the evidence. Who did the vital signs at 2300
hours, 11:00 o'clock?

3

4

A. That is my writing.

5

Q. That's your writing?

6

A. Yes.

7

Q. And the next one, 2345, is that
your handwriting as well?

8

A. That's Susan's.

9

Q. Susan's, so she at some time I
gather, and I think your evidence is to this effect,
that shortly before she went to the echo cardiogram
room with Justin Cook, she came back in and did the
vital signs of the pulse involving Allana Miller?

13

A. Yes.

14

15

Q. And 12 midnight who did the
four vital signs, temperature, pulse, respirations
and blood pressure?

16

17

A. I did.

18

Q. And that is your handwriting?

19

A. Yes.

20

Q. And at 1:00 o'clock?

21

A. That's mine.

22

Q. Now during that time period
from - aside from the one occasion when Susan
Nelles went in at 11:45, do you recall her ever

23

24

25



H9

1

2

going in again up until about 1:45 when some problems
arose with respect to Allana Miller?

3

4

A. No, I don't.

5

Q. Justin Cook was in what room?

6

A. 418.

7

Q. That is right next door to the
nursing station?

8

A. Yes.

9

Q. And 423 is three or four doors

10

down?

11

A. Yes.

12

Q. And do I take it then that during

13

that time period between Janet Brownless, yourself

14

and Susan Nelles on the one occasion, collectively

the three of you were looking after Allana Miller?

15

A. Yes.

16

Q. Anybody else?

17

A. I don't believe so, not at that

18

time.

19

Q. Now I want to deal with something

20

with respect to the monitor. Your recollection is

21

that the monitor started going off with respect to

Allana Miller, was it about 1:00 o'clock?

22

A. It was after 1:00 o'clock.

23

Q. After 1:00 o'clock, and that is

24

25



H10

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

the first time that you were aware that the apex monitor on Allana Miller was going off was at about, or shortly after 1:00 o'clock, after you gave that dose of gentamicin?

A. Yes.

Q. And that is found in Volume 133, page 648 to 649, Mr. Commissioner. So that the monitor, to the best of your recollection, to the best of your sworn recollection, did not go off with Allana Miller at any time from 7:00 o'clock through to after 1:00 o'clock and after you gave this gentamicin.

A. I can't recall that, no.

Q. Well you would be aware of it, you were the team leader, it is something everybody hears I gather, or should hear?

A. I was busy in 418 with Susan Nelles, so I wasn't aware that the monitor had gone off, or there was any problems.

Q. Well would it surprise you that the evidence of a number of different nurses and I will give them to you now, is that that monitor was going off as early as 9:00 o'clock and right through to 1:00 o'clock. The evidence of Susan Nelles at Volume 124, page 8229, is that the monitor



H11

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

was going off between 10:00 and 10:30 even before
Justin Cook came on the ward. Do you recall that?

A. No, I don't.

Q. Bertha Bell in Volume 199 and
at various places at 2332 and 2334, the monitor was
going off as early as 9:00 to 9:30 p.m. and she
went into that room even though it was on 4A and
she was the team leader in 4B. She went past the
nursing station and went in to check the child.
Do you remember that happening?

A. No, I don't.

Q. And the evidence of Marianna
Christie at Volume 7, at page 1535 of the preliminary
was that the monitor was going off at around 10:00
o'clock and she even went in to room 423 to see
what the monitor was doing and what was wrong with
the child. Do you remember that occurring?

A. No.

Q. The evidence of Janet Brownless
is that when she came down, this is at Volume 6 of
the preliminary hearing at page 1426, that even when
she came back on to the ward at 11:00 o'clock the
monitor was going off with Allana Miller, when she
returned to the ward, and again you can't recall that.

A. No, I can't.



H12

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. But in any event, at least your sworn evidence here today as team leader of this team on ward 4A, involving the care of Allana Miller, your recollection is that the monitor did not go off until after you gave the gentamicin at 1:00 o'clock.

A. That is when I remember the alarm going off.

Q. Then from about 1:00 o'clock to 2:00 a.m. the monitor kept going off every five minutes, didn't it?

A. Within a few minutes, yes.

Q. Every five minutes is your evidence on another occasion. Do you want me to read it to you?

A. No.

Q In fact your recollection is that during that time period, from 1:00 o'clock to 2:00 o'clock the monitor was going off so many times that Marianna Christie, Janet Brownless and even Bertha Bell kept going in in addition to yourself, is that right?

A. Yes.

Q. Do I take it that monitors are there for the purpose of going off to warn nurses and when they start going off as frequently as that



H13

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

you become a little bit more worried.

A. Yes.

Q. And in fact you became worried, because I think you were so concerned that you asked Dr. Soulioti to see the child before she left the ward?

A. Yes.

Q. Is that your recollection?

A. Yes.

Q. Now you have told us that you and Janet Brownless, and I think - who else were the ones that were supposed to look after this child while Susan Nelles was dealing with Justin Cook, who is the other nurse?

A. Mrs. Christie was on.

Q. Mrs. Christie. So you expected between the three of you, Janet Brownless, yourself and Marianna Christie that you were going to in effect look after this child in the absence of Susan Nelles up until 2:00 o'clock when she did start to become more involved with respect to the child again.

A. Well she had other children as well.

Q. I understand that. So you were



H14

1

2

spreading yourselves out to look after her because

3

of Justin Cook being on the ward?

4

A. Yes.

5

Q. Now if I look - you have told us

6

already that you collaborated with Susan Nelles

7

about the final nursing note and that is page 42 of

8

the chart, if you would like to look with me at that.

9

Now, according to your evidence, between the time

10

period of 10:30 through to about 2:00 o'clock Susan

11

Nelles, so far as you are aware, saw the baby on only

12

one occasion and that was at about 11:45 when she

13

recorded the heart rate?

14

A. Well she did give medication.

15

Q. She gave the medication at 11.

16

A. Yes.

17

Q. Aside from the medication and

18

then taking the vital signs, anything other that

19

you are aware of that she had anything to do with

20

Allana Miller?

21

A. No.

22

Q. So I take it that if she was

23

going to correctly put the last nursing note in this

24

chart of this dead baby, on page 42, she would have

25

to get some information from you, from Janet Brownless,

26

from Marianna Christie, from Bertha Bell, in order

27

28



H15

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

to properly do it, isn't that right.

A. Yes.

Q. Because it is important I gather,
the final nursing note after a child dies, is that
somebody might be interested in what really happened
about the child.

A. Yes.



26apr84
I
EMTrc

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Q. And if I look at it, you talk about the apex, the blood pressure, the chest, the colour, the behaviour, nutrition and then Nurse Nelles says "Nutrition: tolerated 50 cc. apple juice at 2100", and then she breaks it. She puts a new date, March 21st, as I gather she is required to; puts down "0245 to 0327", which is the date - or is the time of death of this child - and strokes out the "2" of 0245 and puts "1".

If one was looking at that note, there seems to be a four-hour gap between 2100 hours, at least on what happened to that child getting 50 cc. of apple juice and then what happened at approximately 0145.

Now do you agree with me that the nursing note to say the least is incomplete?

A. Could I just read it?

Q. Please do.

A. I don't believe it is incomplete.

Q. All right. Tell me from nine o'clock through to 1:45, if all these other nurses went in there and the monitor was going off and going off and going off, which you say you didn't know, I gather if you collaborated with Nurse Nelles,



I2

1

2

3

4

did you see Janet Brownless, Bertha Bell or Marianna
Christie consult with Nurse Nelles to complete this
note?

5

A. No, I didn't.

6

Q. So it was only the two of you?

7

A. Yes.

8

Q. And you were busy as team

leader and sometimes looking at Allana Miller?

9

A. Yes.

10

Q. And the other people that

11

were looking after her I gather didn't even help
Nurse Nelles to try to complete that note?

12

A. Uhh --

13

Q. What I am getting at is this,

14

wouldn't you want to know as a doctor -- or, sorry,
did you want to say something, please?

15

16

You are quite right, Mr. Thomson.

17

Did you want to say something?

18

A. I was just saying there were

19

reasons why the cardiac monitor may go off and it
may have nothing to do with the child's heart rate.
I wasn't aware that there was any problems up until
after one o'clock.

20

21

22

Q. Well, the trouble with that

23

is the fact that it is noted as being irregular. You

24

25



I3

1

2

3

4

know at seven o'clock, at the start of the shift,
it was regular, then it was irregular all the way
through.

5

6

A. But that wasn't unusual for
this child. She had been irregular for a couple of
days here.

7

8

9

10

11

12

13

14

15

16

Q. So are you saying to me that
the fact that the monitor was going off all shift,
right from nine o'clock on, if that other evidence
is to be believed, is not something that is very
meaningful for anybody looking at this chart after
this baby died? That's not something that we should
be really concerned about, the fact that the nurses
kept having to go in there and resetting the monitor
and looking at the child? That's not really something
that a person trying to find out how and by what
means this baby died would find important?

17

18

A. There were no concerns voiced
to me so I would have to agree with you, yes.

19

Q. I don't understand that.
Forgive me.

20

21

22

23

24

25

A. If the alarm was going off
and the people that had gone into the room had thought
there was something wrong, I am sure they would have
come to either Susan or myself to tell me. They



1
I4 2 didn't -- I don't recall anybody ever coming or
3 voicing a concern or problem with the child. So it
4 could have been just the monitor; very sensitive,
5 that any time she moved it would go off.

6 Q. Do you remember what the
7 monitor was set at on this baby?

8 A. No, I don't, but there's
9 different sensitivity levels, and sometimes just
10 when the child moves or raises her arm the alarm
11 would go off. Or a lead could fall off or be
12 pulled off.

13 Q. Do you recall that occurring
14 with that baby that night?

15 A. No, I don't recall that. No.

16 Q. Your evidence is that you
17 can't recall anything about the alarm going off or
18 anything until after you gave the gentamicin?

19 A. Yes.

20 Q. And I gather that is what
21 you told Susan Nelles when she prepared this note?

22 A. Yes. I think I told her what
23 the child's apex when I did it at midnight was,
24 because she came back and I told her.

25 Q. Surely between one o'clock
and 1:45 if the monitor was going off every five



I5

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

minutes, nurse after nurse was going in to see that child and that you made a point of saying something to Dr. Soulioti, surely those observations between one o'clock and 1:45 are important and should be in the nursing notes?

A. Yes.

Q. They are not. Are they?
Because it starts at 1:45.

A. Well, that's correct, but there is on the flow sheet.

Q. Tell me, under the circumstances if a doctor was, one, trying to find out at the end of the shift, is he going to be looking at the nursing note or is he going to have to go through the chart and find the flow sheet to see what is going on?

A. He could do both.

Q. Have you ever seen a doctor go and look at the flow sheet as opposed to looking at what is supposed to be a complete nursing note?

A. The doctors usually ask the nurses what had happened.

Q. Well, in this case if Susan Nelles had been asked what had happened, she wasn't going to be able to tell that doctor, had she been



I6

1

2

asked?

3

4

A. Yes, she would. I had kept
Susan up-to-date all through the whole night.

5

Q. All right.

6

7

8

9

10

A. Even once the alarm started
going off at one o'clock, I can recall going in to
Susan and telling her the condition of Allana Miller
and what her heart rate was and what was going on,
so she was aware of what was going on with the
children that she was to be caring for.

11

12

13

14

Q. But in any event you agree
with me if that was an important situation, an
important thing to observe and important to Dr.
Soulioti, it sure should be in the final nursing
note?

15

16

17

18

A. I think -- Susan has
summarized it here. I don't know if he wanted her
to put in that the alarm was going off since one
o'clock.

19

20

21

22

23

24

25

Q. If I look at the flow sheet,
if I look at 0234 (I think that is on page 35,36), if
I am a doctor coming and I don't have anybody around
and I want to know what happened to this baby, I look
at the flow sheet: eight o'clock the pulse is 73;
at nine o'clock it is 70; at ten o'clock it is 72;



I7

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

and then at eleven o'clock it is 61; at quarter to twelve it is 60; at midnight it is 59; at one o'clock it is 62.

Now, would I see that there is a whole lot of problems going on? For the past four hours prior to one o'clock the apex varied between 61 and 59. What would I see there as a doctor looking at the flow sheet?

A. I don't believe there was anything different than what her heart rate was. It was in between the 60,62, but the alarm was going off and we had a concern that Dr. Soulioti could just come down before she had left for the night just to check the baby.

Q. In any event following the onset of these terminal symptoms, the baby did die at 3:30. You collaborated with -- I gather you participated in the 28th unsuccessful resuscitation --

A. Yes.

Q. -- involving Allana Miller?

A. Yes.

Q. And at that point you were aware, and you have given evidence already, that in the week before Allana Miller died for the first time you started to become aware of the patterns of the deaths



I8

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

at night with your team. I think that is the evidence you gave to Mr. Lamek. It was some time in the first week or second week of March?

A. Yes, that is right.

Q. Well, it is interesting at this particular point when Baby Miller died that quite apart from a number of babies having died with your team being on the ward, 28 of them, Baby Warner had died on your long night shift of March 6th; Baby Hines had died on your long night shift of March 7th; Baby Gionas had died on your long night shift of March 8th; you were off for three days, your team was off.

The next, March 11th, you lost two babies, Manojlovich and Pacsai; on the next long night shift on March 12th that your team worked you lost Baby Inwood. Then you had some time off.

The next time that you were on, a long night shift and Susan Nelles wasn't there, on March 16th, no baby died. You went through the long night shift without losing a baby.

The next long night shift on March 17th, Baby Gardner died. The next long night shift your team worked was March 20th and Baby Miller died.

Now I guess it must have been something



I9

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

that sure was in your mind when Baby Miller died:
my goodness gracious I have been on this ward for
less than 14 days and I have lost 1, 2, 3, 4, 5, 6, 7,
8 babies in 14 days and there was not one shift --
there was only one shift that went by when Phyllis
Trayner was team leader that we didn't lose a baby,
but the shift previously you had lost two.

Now that was not a very enviable
record, was it, in the month of March?

A. No.

Q. Well, I gather if you haven't
thought about it until March, you sure were thinking
about it a lot when Baby Allana Miller died - another
shift, another death?

A. Yes.

Q. I gather that made you a
little upset?

A. Yes.

Q. It made Susan Nelles a little
upset?

A. I suppose so, yes.

Q. Well, did it, when Baby Allana
Miller died?

A. She was upset that the child
had died, yes.



I10

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. All right. Weren't you saying to yourself, my gracious goodness, do I really want to go in? Tomorrow night are we going to have a ninth baby in 15 days? Didn't you really think that, you know, you were off -- you got off on Saturday morning at seven o'clock. You were due back in the next long night shift and you had been involved in a series of long night shifts. Didn't you say to yourself I don't really want to go in tonight --

A. No.

Q. -- I dread it; I am going to lose another baby?

A. No.

Q. What's happening? You never thought that?

A. No.

Q. So do I take it that even in this time period between the death of Allana Miller and the death of Justin Cook, the 29th baby death, you never felt that you didn't want to go in to work because there may be another baby death occur on your long night shift with your nursing team with you as team leader? You never thought that?

A. I don't believe so, no.



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

111

Q. All right. You were friends at that point with Bertha Bell, were you?

A. Yes.

Q. Bertha Bell said at Volume 119 -- sorry, Sui Scott, one of the members of your team, said at Volume 119, page 7163, when questioned by myself:

"Q. Would it be fair to say that by the end of January you had noticed the pattern and you began to dread going to lunch and then coming back and finding out how your babies were doing?"

A. Yes.

Q. And when did you first mention this pattern to anybody?"

A. I was under the impression that everybody knew about the pattern, all the nurses anyway."

Did you know that Nurse Scott had said that and before this Commission, that by as early as January she was dreading going to lunch on a shift, quite apart from going in the next shift, because she knew another baby death was going to occur or might occur?



I12

1

2

A. No, I didn't.

3

Q. Did she ever express that to
you?

4

5

A. Not that I can recall.

6

Q. Now you were the team leader;
you had four members of your team under you. Are
you seriously suggesting to me nobody ever discussed
these baby deaths, about isn't it awful, how come
they are always occurring on my shift on long nights
after midnight; same terminal events? Nobody ever
said anything to you as team leader at any time until
even Justin Cook died?

10

11

12

13

A. It was as I said before
after Inwood and Pacsai that I can recall that.

14

15

16

17

18

Q. I'm sorry, I want to read
what Bertha Bell said, and I have this here - I don't
have Volume 119. Do you have Volume 119? I just
want to read this, please, if I may. Thank you
very much.

19

20

21

Bertha Bell's reference on this is
at Volume 119, 7163 -- I'm sorry, I have got that
down wrong. You're quite right. I just read that.
118, 6790, sorry.

22

23

No, that is not going to help me,
Mr. Commissioner.

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

But do I take it then under the
circumstances, though, at least as far as you were
concerned in the 12 hours between the shifts involving
Allana Miller and Justin Cook you never really thought
too much about concern with respect to going back
in to work the long night of Saturday night of
March 21st-22nd?

A. Right.



J/BM/ak

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Q. Let me deal then with Justin Cook. Do you have Justin Cook's chart in front of you, Exhibit 116? Now, that baby, as you know, was brought to your ward during your long night shift by Susan Nelles at about 10:30 on Friday night, and we were then at Saturday night at 7 o'clock and you came on shift with Susan Nelles and the members of your team and I gather you took report at about 7 o'clock on Saturday evening?

A. Yes.

Q. As team leader. I gather you were made aware of the welfare and the condition of the babies that you and your team were charged to look after?

A. Yes.

Q. And did you as part of that report, were you made aware of the fact that in the interval between Justin Cook being admitted onto your ward the night before and the beginning of your shift that he was placed on constant nursing care?

A. I was told that at report, yes.

Q. All right. And did you have an occasion to, if I look at Justin Cook's chart, you are aware of the fact that at the beginning of your shift with your nursing team on Saturday evening



1

2

that the child was not on any medication save and
except the Inderal that had been given to him.

4

A. Yes.

5

6

Q. Certainly digoxin had not been
prescribed for him, you see nothing about digoxin in
that whole chart?

7

8

A. Right.

9

10

11

Q. And Dr. Kantak at page 14 of
this chart, and the question of constant nursing care
so far as Justin Cook is concerned, that sort of
order had to come from a doctor, didn't it?

12

A. I'm sorry, at page 14?

13

14

Q. Yes. The child is not put on
constant nursing care by nurses or by team leaders?

15

A. That's right.

16

Q. That must come from the doctor?

17

A. Yes.

18

19

20

Q. And in this particular case
Dr. Kantak talked in terms of the propranolol and
keeping it by the bedside and nothing by mouth from
4:00 a.m. on March 22nd and then constant care?

21

A. Yes.

22

23

Q. Those were the doctor's orders
at 6:30, about a half an hour before you came on
shift that night?

24

25

J2



1

2

A. Yes.

3

Q. Were you aware of that?

4

A. I was told in report, yes.

5

Q. All right. I can understand

6

that that would be the way the order would come for

7

constant nursing care but if I look over at the

8

chart, and I gather the chart was freely available

9

to you as you came on shift and was freely available

10

to Nurse Susan Nelles?

A. I believe so, yes.

11

Q. If you look at page 25

12

Dr. Jedeikin put in this chart some rather interesting

13

comments about the blue spell that had occurred

14

again about half an hour or 40 minutes before you

15

came on this shift at 6:20 on March 21st, at least

16

if I read that correctly. Do you have that in front

17

of you?

A. Yes.

18

Q. And he goes through about what

19

he has decided and the plan about Inderal and what

20

had happened when he gave Inderal or propranolol

21

before you came on shift that the baby started

22

immediately pinking up. But I am intrigued by the

23

last thing about his signature. It says "strict

24

supervision of child". Now, strict supervision of

25



1
2 child, and that is on the progress notes and directly
3 before the last nursing note of Susan Nelles involving
4 your shift and the death of this child. So, I gather
5 that was on that chart at the time you started the
6 shift?

7 A. Yes, it was.

8 Q. So, if anybody had any doubts
9 about whether this child was to be looked after
10 under constant nursing care it was probably under-
11 lined twice over by Dr. Jedeikin's very, very
12 poignant comment on this order "strict supervision
of child"?

13 A. Yes.

14 Q. So, do I take it that it was
15 really a double emphasis and you were aware and
16 certainly the members of your team were aware that
17 that child was to be closely watched?

18 A. Yes.

19 Q. Was Cook, having read that
20 and as a team leader and with your experience, when
21 I say closely watched, and you have agreed with me,
22 what did you anticipate and what were your expecta-
23 tions of what Susan Nelles would do with respect to
24 Justin Cook in the course of giving him constant
25 nursing care over the course of the next 12 hours?



1

2

What were your anticipations as to what she would do?

3

A. She would watch the child

4

closely, be at his bedside.

5

Q. How often would you have

6

expected, in view of Dr. Kantak's order and

7

Dr. Jedeikin's order and the fact that he had had

8

a blue spell half an hour before you started the

9

shift, what would you have expected Susan Nelles
to do with respect to vital signs, observations?

10

A. Well, she would take the vital

11

signs. It was my impression from the report that

12

to disturb the child as little as possible and

13

if that meant not taking the vital signs, he did not

14

want the child woken up.

15

Q. That's why I'm going to go back

16

to that. I gather the child was on a heart monitor?

17

A. I think so.

18

Q. All right. You have difficulty

remembering that?

19

A. Yes.

20

Q. My understanding is that he

21

was but let's leave that aside. So, you don't know

22

and you don't remember. You never remembered seeing

23

the heart monitor on Justin Cook?

24

A. Well, I know we placed him on

25



1

2

a cardiac monitor when he got into trouble.

3

Q. But before that?

4

A. Before the cardiac arrest.

5

No, I can't remember that.

6

Q. In any event, if there was

7

no heart monitor, you have told me that the baby

8

can be asleep and that you as a nurse can find out

9

the pulse by using a stethoscope on the chest of the
child.

10

A. Yes.

11

Q. You can take the respirations?

12

A. Yes.

13

Q. And both of those generally

14

speaking can be taken even though the baby is asleep?

15

A. Right.

16

Q. Do you remember before midnight

17

having taken any of the vital signs on this baby

18

A. No, I don't think I did.

19

Q. All right. So, do I take it

20

that up to midnight in any event, if you relieved

21

Susan Nelles, and it is your recollection that you
did?

22

A. Yes.

23

Q. That because of the fact that

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

J7
you weren't supposed to wake him, and I'm wondering, where would I look in this chart to find out if that was the admonition, don't wake the child. How would I know if I was looking at this chart to know that that is what you nurses believed that it was important not to do with this child? Where would I find that?

A. I don't know if it would be written in the chart. I know that we were given report on this child and it was very explicit from Dr. Jedeikin.

Q. Well, is there anything, if I look at this, can you see anything in the chart? You have obviously looked at Justin Cook's chart a number of times, presumably before today. Can you remember anything in this chart that if I looked at it you would say, oh, that's right, we're not supposed to wake the child, let him sleep and stay in bed and quiet?

A. No, I don't think there was.

Q. But do I take it that your evidence is this, that at some time someone told you that that was what was supposed to be done?

A. Yes.

Q. Was it Susan Nelles that told



1

2

you that?

3

A. It was Marie Mandal and

4

Dr. Jedeikin.

5

Q. I'm sorry?

6

A. And Dr. Jedeikin.

7

Q. Well, did you see Dr. Jedeikin

8

then at the beginning of the shift?

9

A. No, I saw him after midnight.

10

Q. Well, I want to talk about

before midnight, we'll just do it that way.

11

A. Okay, I'm sorry.

12

Q. So, Marie Mandal told you that

13

at the time you took report at 7 o'clock or 7:15?

14

A. Right.

15

Q. She was the team leader on

days?

16

A. Yes.

17

Q. All right. And the constant

18

care nurse that looked after the child was Sui Scott

19

during the day?

20

A. Yes.

21

Q. And I gather she didn't attend

22

report because she remained with the child and Susan

23

Nelles went right from the nursing station to relieve

24

Sui Scott in Justin Cook's room, 418, because there

25



1

2

could not be a time, or there should not be a time
when the child was left unattended.

4

A. Yes.

5

6

Q. Is that your recollection as
to what occurred at 7 o'clock?

7

A. Yes.

8

9

10

Q. So that she didn't take report
and you took report from Marie Mandal and that's
your recollection about what she told you that the
child was to be left quiet whenever possible?

11

12

A. Well, she told me a few other
things as well.

13

14

Q. Well, I am talking about the
vital signs at this point.

15

16

17

Q. Now, were you aware at that
particular time of Miss Nelles' use of what she
described as rough notes?

18

19

A. We usually always have some
rough notes.

20

21

22

Q. All right. Well, were you
aware that she used them as an aid to keeping vital
signs and as an aid to knowing what she was doing
with respect to particular patients?

23

24

25

A. Yes.



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

J10 Q. And in this particular case were you aware that there was in fact rough notes being kept by the bedside of Justin Cook?

A. Well, we have flow sheets.

Q. All right.

A. Fluid intake and output sheets, those are always at the bedside.

Q. Let me look at the flow sheet at page 66 of this chart. Is that the same document?

A. It's not the same flow sheet, no.

Q. Ah, all right, I want to get to that.

The flow sheet that is kept by the bed is not in this chart?

A. That's right.

THE COMMISSIONER: It's the same form though I take it?

MR. PERCIVAL: Q. Same form?

A. No, it is a smaller form and it is used to basically write down the intake of the child and you have a space for intravenous and for timings.

Q. But that's in relation to intake and output?



1

2

A. Yes.

3

Q. I'm talking about the vital

4

signs, temperature, pulse, respiration and blood

5

pressure. Is there some document that was kept by

6

the bed of Justin Cook that you can recall that

7

would permit the nurse who was looking after the

8

child on constant care to record the vital signs

9

that she observed?

A. Yes, there is.

10

Q. What's that, is that this

11

document page 66 or 65 and 66?

12

A. Yes, this is the document that

13

was used, yes.

14

Q. All right. So, do I take it

15

the original of page 65 and 66 were the documents

16

that were kept by the bedside of Justin Cook by

17

Nurse Susan Nelles on that night that Justin Cook

18

died?

A. Yes.

19

Q. And it's not a question of --

20

THE COMMISSIONER: They are

21

inserted in the chart afterwards, is that what

22

happened?

THE WITNESS: This sheet would

23

be, the other fluid --

24

25



1

2

THE COMMISSIONER: I'm sorry, which
one are you referring to?

4

THE WITNESS: Well, the other fluid
sheets we keep on all our infants, we keep maybe two,
three, four shifts.

6

7

THE COMMISSIONER: We have had all
that before. But do you take the flow sheet from
pages 65 and 66, is it kept by the bed?

8

9

THE WITNESS: If a child is on
frequent vital signs every 15 minutes, every half
an hour, every hour, yes, it would be.

10

11

12

THE COMMISSIONER: And a constant
care child would probably be on that sort of thing?

13

14

THE WITNESS: Yes.

15

THE COMMISSIONER: So, in this
particular instance you think that this flow sheet
was beside the bed and was recorded from time to
time by whoever was recording it?

16

17

18

THE WITNESS: Yes.

19

THE COMMISSIONER: Presumably in
this case it would be Susan Nelles?

20

21

THE WITNESS: Yes.

22

THE COMMISSIONER: And then after
the child dies or at some point if the child didn't
die at the end of the session it would be inserted

23

24

25



1

2

in his chart?

3

THE WITNESS: Yes.

4

5

THE COMMISSIONER: And what is the
other flow sheet that you are referring to?

6

7

THE WITNESS: It is a fluid record
sheet and it is just a scrap piece of paper.

8

9

10

THE COMMISSIONER: Well, if you
have one where a child is on every hour vital signs
you would have this other sheet as well, would you
keep the other sheet as well?

11

12

13

THE WITNESS: You may, yes, if he
is on intravenous and if you want to keep track of
the intravenous fluid.

14

15

THE COMMISSIONER: Yes. Well, I
don't think I quite understand this yet.

16

17

MR. PERCIVAL: Well, I think I'm
going to keep on with it if I may.

18

19

20

21

22

Q. What I would like to know is
this. You have told me that you believe that,
involving the question of Justin Cook, 65 and 66
were the actual documents that were by the bedside
when you relieved Susan Nelles at the times that you
have indicated that you have before he died?

23

A. Yes.

24

25

Q. Now, was that a practice that



1
2 was followed by all the members of your team or did
3 some members of your team keep what is called a
4 rough flow sheet by the bed and then at the end of
5 the shift because there were chicken scratchings and
6 water being spilled on it and stuff like that that
7 they went back to the chart, took another flow sheet,
8 threw three out and copied it all so that it all
9 looked very neat and nice for the chart. Which was
10 it, what occurred?

11 A. If the children were on
12 frequent vital signs the flow sheets from the chart
13 would be in the room unless of course the child was
14 in isolation, then there may be a flow sheet that
15 you would keep to yourself.

16 Q. I want to deal with just
17 constant nursing care such as we have with Justin
18 Cook. Then, as I understand you, this flow sheet,
19 65 and 66 was the flow sheet that you believed
20 was kept by the bed of Justin Cook and was recorded,
21 a record was made of it by Susan Nelles and anybody
22 else who would relieve her who would take vital
23 signs?

24 A. Yes.

25 Q. And then at the end of the
shift or at the death of the child it would be put



1
2 into the chart and then shipped off to medical
3 records?

4 A. Yes.

5 Q. All right. Now, do you
6 recall, so far as Justin Cook is concerned, on that
7 night whether or not the flow sheet and that other
8 sheet that you have talked about, a scrap piece of
9 paper for the question of the IV, do you recall
10 whether those were the only documents that were
11 by the bedside or whether the complete chart was
by the bedside?

12 A. It was just these two sheets
13 and the other sheet.

14 Q. And the other one, all right.
15 Now, I was intrigued by your answer to the
16 Commissioner that the fact that you expected, at
17 least given the fact that this child had a blue
18 spell a half an hour before you started, that vital
19 signs were important, close attention was important,
20 did you anticipate Susan Nelles would be taking
vital signs every 15 minutes with this child?

21 A. No, I didn't.

22 Q. Well, if you did take them
23 every 15 minutes you would expect them to be on
24 the chart I gather?
25



1

2

A. Yes.

3

Q. There would be no reason why

4

she couldn't do that because the chart, that

5

particular document would be right beside the bed?

6

A. Yes.

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25



26apr84
K
DMrc

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Q. And if I look at this

document -- I'm sorry. Thank you. Before I leave that previous one, and I will come to that; Exhibit 154, Mrs. Trayner, is a document which is called a Fluid Record Work Sheet, and this has been marked an exhibit before. Is that the type of document that was kept by the bedside for intra-venous fluids, fluids in-fluids out?

A. Yes, it is.

Q. And a nurse would complete that at the bedside and then transpose that to something else?

A. You could transpose it over to the flow sheet at the end of your shift, but it is for writing little notes and helping out with your charting at the end of the day.

Q. Why wouldn't you -- Mr. Commissioner, you have seen this?

THE COMMISSIONER: Yes, I have it here.

MR. PERCIVAL: Q. That was, I see in Exhibit 154 seems to be the same sort of information as I see in the flow sheet, which is 65, 66, which goes in the chart. Is there something more that is on the Fluid Record Work Sheet that could not be



K2

1

2

put immediately on to the flow sheet by the bed?

3

What is there? I am sorry, have I missed something?

4

A. On page 65 and 66?

5

Q. Yes.

6

A. What we do is we give it a

7

12-hour total. We don't write in every time the

8

child takes 30 cc. On to this sheet. We can do it

9

here on 154 and at the end of the day we just total

10

it all up, the intake, the output, the amount of

IV, it is only one column, as Susan has done.

11

Q. Do I take it that if I look

12

on the far right columns, there is certainly a

13

provision on an hourly basis if one wanted to to

14

put in exactly what was going in and what was going

15

out on an hourly basis and then total it at the

16

bottom? I mean, does not that particular sheet, that

17

flow sheet, facilitate its use at the bedside and it

18

could do the very thing that 154 seems to be able to

do? Have I missed something?

19

A. It is not a legal document

20

for the chart, that's all.

21

Q. If you have the flow sheet

22

sitting by the bed and there is provisions every

23

hour, or as long as you want to do it, for intake/

24

output, you could write all that down just the same

25



K3

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

as you write down the pulse, the respiration, the temperature and the blood pressure? Isn't that so?

A. You would be wasting time writing it down twice then.

Q. You are wasting your time, are you not, surely by having to take the document out, do the totals and then just put down a total? Surely you are wasting time that way?

A. No. The vital signs would be kept here, they are already recorded, they are right here; you don't have to recopy them at the end of a shift. All we are recopying is how much the child has put out and how much the child has put in.

Q. Mrs. Trayner, I am sorry, maybe I am -- I have missed it and perhaps you have. If I look at the far right columns of 65 and 66 it says:

"20-hour total intake and output" and then there is box after box after box with a total that can be put at the bottom. Is there any reason why if you are on an hourly basis, for instance, saying 30 cc. in/40 cc. out by way of urine, and then total them at the bottom? Doesn't that particular document, accordingly, if it is to you



K4 1
2 at least to you a legal document, something that
3 would be perfectly satisfactory doing it as you
4 went along? I am talking about intake and output.

5 A. But then you still have to
6 place it back into this chart as well.

7 Q. That is what I'm talking
8 about. 65, 66, if you had that document at the
9 bedside, surely you could end up giving it on an
10 hourly basis what went into the child and what went
11 out of the child, and there are columns for that and
12 a total for that.

13 A. You can't do that, that isn't
14 part of the POMR charting.

15 Q. What is the purpose then of
16 having box after box after box and then only one
17 box filled in at the bottom for total? I don't
18 understand that. Maybe you can --

19 A. What we have done is a 12
20 hour total and then we do a 24 hour total, which
21 you can see over here at the end. It says 24 hour
22 intake and output.

23 Q. I will leave it because I
24 am as confused as I was at the beginning, and you
25 will forgive me, Mrs. Trayner, it is probably because
of my ignorance involving the matter. Somebody else



K5

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

will have to make that decision.

THE COMMISSIONER: I am confused too but I am beginning to wonder, does it matter. If it doesn't matter whether I am confused or not, I really don't think that this case, if I can call it that, is going to stand or fall on whether --

MR. PERCIVAL: Quite right, Mr. Commissioner. All I was trying to do was find out what was there that night.

THE COMMISSIONER: Yes.

MR. PERCIVAL: Q. Let me deal with the vital signs then on page 66. Do I take it that for whatever reason Nurse Nelles commencing at eight o'clock at the top of page 66 recorded on this record the vital signs, temperature, pulse, respirations and blood pressure of that baby at eight o'clock?

A. Yes, she did.

Q. Are any of the handwritings on page 66 in your handwriting?

A. I believe 2350 may be mine.

Q. So do I take it then that you did, contrary to what you told me a few minutes ago, that you did, at least in relation to this child, record vital signs on at least one occasion?

A. Yes.



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

K6

Q. Does that give us the time at approximately before midnight that you relieved Susan Nelles?

A. Yes.

Q. And that was the time just before she came back and then asked for five more minutes to go get a newspaper?

A. Yes.

Q. And is there any reason that between eight o'clock and 2350 why the temperature wasn't taken? Was the baby sleeping all that time?

A. We don't usually take the temperature every hour; it would be every four or six hours.

Q. Well if I look back on this baby it looks like the temperature was done on an every four hour basis, was it not?

A. On every four?

Q. How do you know how often the temperature is supposed to be taken? Is there some order in the chart to tell you when you are supposed to do it?

A. There may be. He just had a cardiac cath. done that morning so we have a



1
K7 2 routine that we follow.

3 Q. What was the routine?

4 A. It is every 15 minutes for
5 the first hour.

6 Q. Yes.

7 A. It is every half hour for
8 the next four hours.

9 Q. Let me follow this. At
10 page 65 is this why we have got in the afternoon
11 at 1445, 1515 and 1545? Are we then into the half
12 hour monitoring of the child?

13 A. Yes.

14 Q. And then -- I am sorry, my
15 copy is very poor. The next time when four vital
16 signs are taken is at 1645, which would be 4:45 in
17 the afternoon?

18 A. Yes.

19 Q. And then I see the tempera-
20 ture is not taken again until Susan Nelles takes it
21 again at eight o'clock?

22 A. That's right.

23 Q. And it would appear that at
24 least whatever occurred between Sui Scott and Nurse
25 Nelles, that when she came on shift it became her
practice to start to record it on an hourly basis?



K8

1

2

A. Yes.

3

Q. Is that satisfactory for a baby who is supposed to be under constant nursing care and under strict supervision, as the doctor's orders indicated, was that appropriate?

6

A. Yes.

7

Q. Because it is recorded every one hour, do I take it from that that no close observations of either pulse or respirations was taken in between the hours?

10

A. Well, there is nothing recorded on the chart.

12

Q. What I am getting at, if Susan Nelles thought that the child should be closely observed and say at 9:30 decided to take the pulse and the respirations, there would be nothing to prevent her from taking it and nothing to prevent her from recording it because the document is right beside her?

18

A. Yes.

19

Q. And 2350 I find that rather unusual, because it is recorded on the hour up to the point where you became involved in the chart of this child and it is not 12 o'clock, it is 2350, what was the reason for that and when was that placed on

23

24

25



Trayner,
cr.ex. (Percival)

1
cr 2 there? Why didn't you wait until Susan Nelles came
3 back to do the vital signs, was there some reason?
4 A. He may have been asleep at that
5 time and I thought I would check his apical rate and
6 his respiration and write them down for her.
7 Q. Did you feel that because you
8 were relieving a child on constant care that you would
9 feel obligated to leave again your mark on the chart
10 to indicate that you were there?
11 A. No, I didn't do it for that
12 reason.
13 Q. Do you specifically remember
14 taking the vital signs, the pulse and respiration
15 with this child at 10 minutes to 12?
16 A. Yes.
17 Q. You do, and you don't know why
18 I gather. Why you didn't wait 10 more minutes if
19 it was to be taken on an hourly basis?
20 A. My watch may have said 12
21 o'clock.
22 Q. Why would you record it 2350
23 then?
24 A. I don't know why I took it
25 at that time. It could have been he was in my arms
and it was comfortable for me to take it at that time.



10

1

2

I really don't know. I knew it had to be done so
I did it.

3

4

5

6

7

8

9

Q. Then you have told us in your
evidence that Nurse Nelles came back, you went on and
resumed your duties as team leader. The next vital
signs are shown at 1 o'clock and then something
happened, and that is I gather at 1 o'clock Susan
Nelles' observations and handwriting?

10

11

12

A. Yes.

Q. And then the next vital signs,
and maybe my copy is wrong, but it seems to be 3
o'clock, there seems to be a jump of two hours?

13

14

15

16

17

A. That is 2 o'clock.

Q. Is it 2?

A. Yes.

18

19

20

21

22

23

24

25

Q. So that is 2 o'clock, and at
that time all four things are taken, temperature,
pulse, respiration and blood pressure?

A. Yes.

Q. Is it your recollection that
you relieved Susan Nelles before or after 2 o'clock
involving Justin Cook?

A. It was after she had taken the
2 o'clock vital signs.

Q. And you remember that because



11

1

2

you remember that he had a slightly elevated
temperature?

3

4

A. Yes.

5

Q. From 38 up to 38.6?

6

A. Yes.

7

Q. Is that your evidence?

8

A. Yes.

9

Q. So it was shortly after 2

o'clock. Did you see her take the vital signs?

10

A. I don't recall that, no.

11

Q. In any event you saw from the

flow sheet the vital signs recorded at 2 o'clock
when you relieved her?

12

13

A. She told me.

14

Q. But you could also see it was

in the document?

15

16

A. Yes.

17

Q. And it was right by the bed?

18

A. Yes.

19

Q. And then I think your evidence

is that you started to feed the baby?

20

A. Yes.

21

Q. And how long did you remain

with the baby before Susan Nelles came back from
lunch break?

22

23

24

25



Trayner,
cr.ex. (Percival)

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. I was with Justin probably about 10 minutes, 15 minutes, and he fell asleep in my arms and I put him back in the bed and he started crying, and that is when Susan came back in to see what was wrong.

Q. I want to deal though with your time period that you were with this child, quite apart from Susan Nelles popping back in and popping back out. How long was it in total that you feel that you relieved Susan Nelles for the lunch break after midnight?

A. About 30 minutes, 45 minutes.

Q. Well then - do you remember during that time period taking the vital signs?

A. No, I don't.

Q. And for whatever reason the next vital signs were not taken for another hour and 45 minutes, at least according to the chart?

A. Yes.

Q. And if I follow the practice that had occurred since about - from about 6 o'clock before, the vital signs being done almost every hour, can you give me an explanation as to why there would be a gap of an hour and 45 minutes when this child, apparently with the flow sheet right beside the child,



1
2 no attempt was made to record vital signs of this
3 child until the time the child commenced to go into
4 terminal cardiac events?

5 A. No, I can't.

6 MR. PERCIVAL: Would this be a
7 convenient time?

8 THE COMMISSIONER: Yes, all right.
9 We will rise - are you all right?

10 MR. PERCIVAL: Yes, I think I am going
11 to be all right. As you can appreciate, so far as
12 finishing I am doing it in a bit of a chronological
13 order from this standpoint. I would prefer to start
14 at 2 though to be on the safe side, Mr. Commissioner.

15 THE COMMISSIONER: Yes, all right.
16 No, that's fine, we will come back at 2.

17 MR. PERCIVAL: Thank you.

18 ---Luncheon recess.
19
20
21
22
23
24
25



26apr84
AA
EMTrc

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

--- on resuming at 2:00 p.m.

THE COMMISSIONER: Yes, Mr.
Percival.

MR. PERCIVAL: Thank you, Mr.
Commissioner.

Q. Now, I want to deal with
your involvement with Baby Cook and that of Susan
Nelles, and as I understand your evidence, and if
I start at seven o'clock, that shift in conjunction
with you and Susan Nelles, if constant nursing care
was to be obeyed by the spirit as well as the letter
between you and Susan Nelles, you were with that
baby one hundred per cent of the time up until the
time it went into its terminal events shortly after
three o'clock?

A. Yes.

Q. And you never fell asleep
when you relieved Susan Nelles?

A. No, I didn't.

Q. And you never saw Susan
Nelles fall asleep while giving constant nursing
care to this baby Justin Cook?

A. No, I didn't.

Q. And you never saw anyone
at any time that you were in Room 418 administer any



1

2

parenteral digoxin into the buretrol or the IV

3

tubing that you saw?

4

A. No, I didn't.

5

Q. And it would be very hard

6

I suggest if you were giving and Susan Nelles were

7

giving that baby constant nursing care and strict

8

supervision as the doctors had suggested, for anyone

9

to come in and do that into the IV tubing in your
presence or in Susan Nelles' presence?

10

A. Yes.

11

Q. And as I understand your

12

evidence to Mr. Lamek, and this is found in Volume

13

134, pages 810 through to 812, you were asked by

14

him at some length, and I think that you said you

15

did not administer digoxin to Justin Cook?

16

A. That's right.

17

Q. And if Susan Nelles didn't

18

administer digoxin to Justin Cook and the two of you

19

were there at least one hundred per cent of the time

20

and maybe sometimes two of you were there at one time,

21

the only explanation as I heard you say that this

22

baby could have got digoxin into its system in the

23

course of that long night shift was because of some

24

confusion about the Inderal or the propranolol

25

ampules that were taped as you say to the bottom of



1

2

the bed?

3

A. Correct.

4

Q. All right. And do I take
it that that explanation - that is your only
explanation that you proffered to Mr. Lamek - was
based upon your perception that that medication
might have been digoxin as opposed to Inderal?

8

9

A. I don't know what was in that
syringe.

10

11

12

13

Q. No, I understand that, but if
we are to follow your explanation through, that would
be premised upon the fact that that which was taped
to the bottom of the bed was digoxin and not Inderal?

14

15

16

17

A. Right.

Q. Is that correct?

Now I want to look -- do I take it
you know what an ampule of Inderal or propranolol
looks like?

18

19

A. Yes.

Q. Did you know that back in
March of 1981?

20

21

22

A. Yes.

Q. And did you know the colour
of it?

23

24

25

A. The vial?



1

2

Q. Yes.

3

A. Yes.

4

Q. What is it?

5

A. It is a smokey colour.

6

Q. All right. Maybe if you

7

look at Exhibit 225, which are the ampules which
have been filed here that were apparently -- I am

8

showing to you an ampule of Inderal, and is that

9

(that is one of the four in this set in Exhibit 225),

10

and is this the vial or ampule of injectable Inderal

11

that was commonly used on the ward in March of 1981?

12

A. Yes.

13

Q. And is that the smokey

14

coloured ampule --

15

A. Yes.

16

Q. -- that you are talking about?

17

And the digoxin by comparison, the digoxin ampule,
whether it is parenteral or pediatric, is a clear
ampule, is it not?

18

A. Yes.

19

Q. And if one looks at it, you

20

would have no difficulty in seeing something which
is smokey and something which is clear?

21

22

A. Right.

23

Q. Do you agree?

24

25



1

2

A. Right.

3

4

5

6

7

8

9

10

A. Yes.

11

12

13

14

A. Yes.

15

16

17

18

19

20

21

22

23

24

25

A. Yes.

Q. Yes. You knew that was all there before the events, the critical events involving the death of Justin Cook took place?

A. Right.

Q. So I gather -- is it fair to



1

2

3

4

say that when you saw the ampules taped to the bottom of the bed, you probably saw an ampule which was smokey coloured and not clear?

5

A. Right.

6

7

8

9

Q. All right. So do I take it if we accept all of that, it is not likely, is it, surely that the two ampules that were at the bottom of that bed were in fact digoxin as opposed to Inderal? Based upon all what you knew.

10

A. With all that, no.

11

Q. No.

12

A. But they were drawn up, they were in syringes.

13

14

15

Q. I understand that, but the ampule was still there and it was a smokey coloured ampule?

16

A. Okay.

17

18

Q. Nothing triggered suspicion in your mind?

19

A. No.

20

21

22

23

24

25

Q. All right. And if pharmacologists give evidence to the effect that whatever was injected and if that happened to be in the syringe, digoxin, even if it was injected at the time Inderal was supposedly injected by the doctors



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

in the early morning hours of March 22nd, that that in that dosage and at that time would not result in the sky-high digoxin level for Justin Cook, then do you agree with me that that really throws your explanation, the combination of all that, into no explanation at all? If the Commissioner accepts that evidence.

THE COMMISSIONER: I'm sorry, I am having a little difficulty with that. You say if the doctor...

MR. PERCIVAL: If there is evidence, other evidence --

THE COMMISSIONER: Yes.

MR. PERCIVAL: -- that that which was injected which was thought to be Inderal was in fact digoxin --

THE COMMISSIONER: Yes.

MR. PERCIVAL: -- that could not have at that time in that dosage resulted in the in-excess-of-100 reading on Justin Cook.

THE COMMISSIONER: Ante mortem.

MR. PERCIVAL: Ante mortem. I said if there is that evidence.

MR. THOMSON: Well, I'm sorry, is Mr. Percival telling the witness there is that evidence?



1
2 Because otherwise you are saying if in the air -- I
3 mean tomorrow is Sunday --

4 MR. PERCIVAL: Well, Mr. Commissioner,
5 there is that evidence.

6 THE COMMISSIONER: I think there is
7 that evidence that it has to have some time to take
8 effect.

9 MR. PERCIVAL: Yes.

10 THE COMMISSIONER: That is the point
11 you are making because if the time between the dosage
12 of the Inderal and the taking of the ante mortem
13 blood from the child --

14 MR. PERCIVAL: That's right.

15 THE COMMISSIONER: -- is insufficient --

16 MR. PERCIVAL: For it to take
17 effect.

18 THE COMMISSIONER: -- for it to take
19 effect and to create that reading.

20 MR. PERCIVAL: That is correct.

21 THE COMMISSIONER: Well, that is a
22 reasonable hypothetical question, whether the
23 evidence exists or not.

24 MR. PERCIVAL: Thank you.

25 Q. Do you understand what we are
getting at, Mrs. Trayner, that if there is evidence



1
2 that is accepted by this Commissioner that what was
3 apparently Inderal given to this child at the time
4 specified in the chart and was in fact digoxin, it
5 could not have resulted in the excess-of-100-nanograms
6 reading in Justin Cook at the time of his death.

7 A. Yes.

8 Q. And if that's the evidence,
9 then I gather your explanation, your alternative
10 explanation, a combination of the ampules and that
11 sort of evidence, really puts that possibility into
12 the realm of very, very slight possibility, does it
13 not?

14 A. Right.

15 Q. Then one is then forced to
16 retreat to the situation that if you were doing your
17 job in constant nursing care and Susan Nelles was
18 doing her job in constant nursing care and the child
19 was with a nurse one hundred per cent of the time,
20 some time during that shift before he went into
21 terminal events, something was administered to his
22 body in either your presence or that of Susan Nelles?

23 A. Right.

24 Q. Thank you. Now I am not going
25 into the evidence involving the digoxin lock-up and
the mystery, if I can use that expression as Mr. Lamek



1
2 says we will never know where that small bottle of
3 digoxin elixir went or did not go - I am not going to
4 go into that, but I do recall your evidence that on
5 occasions during the early part of that shift Dr.
6 Costigan and Dr. Mounstephen came in, there was a
7 hold. You threw out the digoxin that you had drawn
8 up and then he eventually gave you further information
9 between 9:00 and ten o'clock. You drew up further
10 digoxin, had it checked with Bertha Bell and then
administered it to your children?

11 A. Yes.

12 Q. And you never administered
13 any digoxin to Justin Cook because it was not
14 specified for him?

15 A. That's correct.

16 Q. All right. And again there
17 seems to be some confusion about when the digoxin
18 was finally all locked up in 4A/4B, but it is fair
19 to say, is it not, that by midnight of March 21st/22nd,
20 the digoxin, whether it was on 4A or 4B, was in fact
21 all locked up in the narcotics cupboard?

22 A. Well, it was locked up on
23 4A by midnight.

24 Q. All right. Well, at least
25 up until midnight I suggest to you the possibility and



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

the probability was that in both of those medications rooms somebody could have walked in the door and helped themselves to parenteral digoxin and put it in their pocket during the course of that shift? Someone could?

A. Yes.

Q. And someone could have carried it around on their person during the course of that shift before it was locked up and had it available to inject into the body of Justin Cook if they so wished to after midnight?

A. Yes.

Q. One wouldn't have to go out to a drugstore to get it?

A. Right.

Q. And I think you told us already that the type of people that would go into the medications room and not likely be noticed, if I can use that expression, are Registered Nurses surely?

A. Yes.

Q. And from time to time to get aspirins and other things you have seen doctors go in there. Do you recall doctors, residents or Fellows going in there that night in the medications



1

2

room of 4A or 4B?

3

A. Dr. Jedeikin.

4

Q. You saw him go in?

5

A. Yes.

6

Q. And he was accompanied by who?

7

A. He went in by himself.

8

Q. And you knew what he was
going in for, didn't you?

9

A. I knew he was going in for --
he was looking for a drug.

10

11

Q. All right. And this was
another drug; not digoxin?

12

A. Right.

13

Q. And in fact he didn't find it?

14

A. Right.

15

Q. And he went in there and

16

came out and then you had to make a phone call I
think to Miss Johnstone --

17

18

A. Right.

19

Q. -- who came down and then
took him down to Pharmacy?

20

A. That's correct.

21

Q. So that was really not an

22

unusual event, was it?

23

A. No.

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Any other occasions in the course of that night shift between seven o'clock and after midnight where you noticed a doctor, a Fellow or a resident going into either medications room?

A. Only the two that I was with when we did...

Q. All right. But you were personally present with them?

A. Yes.

Q. And neither Mounstephen nor Dr. Costigan retained any parenteral digoxin that you could see?

A. No.

Q. And you were in close proximity to them?

A. Yes, I was.

Q. Now one thing I haven't talked about, and you have said that nurses could go in there and would be unnoticed. What about nursing assistants? Would nursing assistants from time to time go into the medications room and it would be something that would go unnoticed by anybody else on the ward?

A. Yes.

Q. All right. They would not go



1

2

in there to get medication, surely. They would go

3

in there for some other purpose?

4

A. Yes.

5

Q. What was the other purpose?

6

I'm sorry, that evidence has been given and I must
confess I don't recall it.

7

A. Well, they could go in for

8

some spoons, for some medicine cups.

9

Q. For aspirin?

10

A. Yes.

11

Q. But they sure would not -- it

12

would be pretty unusual if you saw them coming out

13

of the medications room with some medication which was
other than aspirin or a spoon?

14

A. Yes.

15

Q. Because they are not supposed

16

to be involved with medications, whether it's digoxin

17

or antibiotics or any of that?

18

A. That's right.

19

Q. All right.

20

THE COMMISSIONER: The witness

21

agrees with you but I am having some trouble with

22

that. They are not supposed to administer medication

23

but can't they get medication or couldn't you ask a

24

Registered Nurse's Assistant to go and get medication

25



1

2

for you?

3

4

5

6

THE WITNESS: I don't know if we would ask them to do that. We may ask them to give the child medication after we have drawn it up, if they are busy when we go around.

7

8

THE COMMISSIONER: But you wouldn't ask them to go and get it - you would go and get it yourself?

9

10

11

THE WITNESS: No, not for a patient. They might go and get medicine for themselves if they wanted an aspirin.

12

THE COMMISSIONER: Oh, I see.

13

14

15

16

17

MR. PERCIVAL: Q. So in any event do you recall on that night shift then that Justin Cook died seeing any Registered Nursing Assistant, whether from 4A or 4B, go into either medications room that you could recall prior to the digoxin being finally locked up?

18

A. Not that I can recall.

19

20

21

22

23

24

25

Q. All right. Now when the digoxin was being locked up at the request of Dr. Costigan and Dr. Mounstephen I think at Volume 133, page 700, there was some discussion between yourself and Bertha Bell and Susan Nelles. Do you remember giving that evidence? And let me read it to you. It



1
2 is starting at the bottom of page 699:

3 "Q. All right. Did you ask
4 Costigan why that was being done?
5 Why was it necessary to check the
6 concentration?

7 A. I don't know if I had asked
8 him then. I had asked him if there
9 was a problem with it and he just
10 said that they just wanted to check
11 out the concentration to make sure
12 what was said on the bottle was
13 exactly what was inside the bottle.

14 Q. And did you repeat to Miss
15 Nelles everything that had passed
16 between you and Dr. Costigan?"

17 A. I was on my way in to tell her
18 and I got half of the story out when
19 Bertha had come in and said 'Did
20 you hear about the digoxin?'

21 Q. All right. So there were now
22 three of you in the room?

23 A. Yes.

24 Q. All right. Let's start with --
25 you have told us what your reaction
was to the instructions. Did either



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Mrs. Bell or Miss Nelles say anything about the instructions that had been given by Dr. Costigan?

A. Just that it was strange, that it was unusual, and there was a comment made that something big was going on.

Q. Do you recall who said that?

A. No, I can't. There was three of us in the room at the time."



BB/BM/ak

1
2 Now, that's your recollection of
3 what occurred today?

4 A. Yes.

5 Q. If I look at your notes, your
6 personal notes which I think have been marked as
7 Exhibit 396, that same comment about something big
8 is going on is found, if I look at Exhibit 396, the
9 third line down on page 2 where you relate that:

10 "Put NARVEL on the desk. Relieved Sue
11 for coffee - asked Sue to lock up dig.
12 Something big going on."

13 Again, that was the phraseology that
14 was used by you. Do I read that correctly?

15 A. I'm sorry, what page?

16 Q. On page 2.

17 A. Yes.

18 Q. All right. Now, I want to
19 end up - you have told us that that particular
20 exhibit were your personal notes made on March 25th
21 of 1981 at which time you were trying to reflect
22 back on what you had told the police officers
23 earlier that day?

24 A. Right.

25 Q. And you have in fact looked at
your statement of March 25th, 1981 that was given



1

2

3

4

to the police officers, it is extensive, it goes on
some 24 pages. You have had a chance to look at that,
have you?

5

A. Right.

6

7

Q. And I will put it to you again
because I want to refer to it if I may.

8

9

Mr. Commissioner, for your assistance
I will perhaps give you a copy. Do you have one,
Mr. Thomson?

10

11

MR. STRATHY: No, not the hand-
written ones.

12

13

14

15

16

17

MR. PERCIVAL: Q. And if I look
at this particular handwritten copy, which is signed
on each and every page by you, Mrs. Trayner, if I
look at this, your own notes, and I look at pages 15
and 16 I find something there that relates to the
same subject matter and where you say at the bottom
of page 15:

18

19

20

21

22

"At about 0030 hours I went into 418
and told Sue, did you hear they are
counting the digoxin and she said
she heard them out there, she said
there must be something big going on."

23

24

25

MR. STRATHY: Is it 'I said' or
'she said'?



1

2

THE WITNESS: I said.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MR. PERCIVAL: Q. And I said or

she said, you are quite right. Is that your
recollection, it was either you said there was
something big going on or Susan Nelles said there
was something big going on?

A. Yes.

Q. And your recollection, at least
on March 25th, was that that discussion took place
after midnight because you are very precise it is
about 0030 hours

A. Yes.

Q. That's what it says, whether
it is right or wrong, I want to know, first of all,
is that what it says?

A. Yes, that's what it says.

Q. And is it your recollection
today that that discussion, either you saying it
or Susan Nelles having said it, took place before
or after midnight and before or after you relieved
her for the coffee break?

A. I thought it was before I
relieved her for the coffee break and I thought it
was just after Dr. Costigan had come around and
told us to hold the digoxin and it was about shortly



1
2 after 10:00 that he came back and said, no, you can
3 give it out.

4 Q. Do I take it also, Mrs. Trayner,
5 in fairness to you, you did not have the complete
6 chart in front of you at the time you were being
7 questioned by these officers on the morning of
8 March 25th?

9 A. Yes.

10 Q. So, what you were trying to
11 do was resurrect in your memory four days before what
12 had happened on the eventful night of Justin Cook's
13 death?

14 A. Yes.

15 Q. All right. But I want to know
16 whether or not you said it or whether Susan Nelles
17 said it, someone said "Something big is going on",
18 and do I take it from what you have said is that
19 a big investigation, is that what you mean?

20 A. I don't --

21 Q. First of all, if you said it
22 what would you mean by that "Something big is going
23 on". I will take the two alternatives.

24 A. I probably would have meant
25 that something was going on with the digoxin and
the Pacsai case.



1

2

Q. All right.

3

A. The coroner's inquest.

4

Q. Do I take it what you mean is that there was an investigation going on, it was something big, something significant? It is your terminology both in your notes and in your statement and I want to know what you thought it meant. Something big, something extensive, something important.

10

A. Yes.

11

Q. And an investigation into digoxin.

12

13

A. Well, yes, they were looking at digoxin.

14

15

Q. All right. And you related it immediately, at least in your mind, to the Pacsai inquest and the high digoxin level?

16

17

A. Yes.

18

Q. Right. Certainly that was discussed by you and Bertha Bell and Susan Nelles, if I look at your statement again on page 7, you were talking in terms of, if I look at the top, page 7:

19

20

21

"I went into Room 418 and told Susan Nelles there was a problem with the digoxin and we were to hold it. At

22

23

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

"this point Bertha Bell came into Room 418 and said something like did you hear the news on the digoxin. Sue said no, Phyllis was just telling me. Then Bertha said something about the concentration being higher in the one sample. Someone said maybe that is why the level is so high in Pacsai."

Now, do you recall the events now having refreshed your recollection from the statement given on March 25th?

A. Yes.

Q. All right. Now, did you think that the something big that was going on, the investigation, the extensive investigation that was going on was something that the coroner was doing or that the Hospital was doing or did you even think about that?

A. I don't know if I thought of that or if it was the Hospital or the coroner. I put it together that it had something to do with Kevin Pacsai and the digoxin.

Q. All right. And that they were checking concentrations and then later in the shift, whether you put it together at the beginning



1

2

of the shift, later in the shift you were told by
Dr. Costigan that you not only double checked the
digoxin, that you double signed digoxin.

5

A. Yes.

6

7

8

9

Q. And later in the shift you
were told that at least for tonight until you get
one of those wonderful pink memorandums that all
the digoxin, all kinds of digoxin was going to be
locked up on your ward.

10

A. Yes.

11

12

13

14

15

16

Q. All right. And did that
sort of reinforce the fact that, at least so far
as you were concerned, there was a significant
concern, a significant investigation going on,
whether it was by the Hospital or by the coroner,
about digoxin at that point?

17

18

A. There was something with
digoxin and something with Kevin Pacsai. I thought
it might have to do with the inquest.

19

20

Q. All right. But you had never
seen that happen before?

21

A. Right.

22

23

24

25

Q. And digoxin was like water in
many respects in this cardiac ward, it was often
used by many of the babies?



1

2

BB8

A. Yes.

3

Q. Right. And to that extent

4

it was a most unusual turn of events, as you

5

perceived it that night of Justin Cook's death.

6

A. Right.

7

Q. All right. I want to deal

8

with one matter about Justin Cook. We have heard

9

some evidence and I gather were aware, and are

10

aware even at this moment, that Marianne Christie

11

has given evidence in these proceedings about the

12

drapes or curtains around Justin Cook's bed after

13

midnight and just before he went into the terminal
events of his death.

14

A. Yes.

15

Q. Did you read her evidence?

16

A. I heard it on T.V.

17

Q. Well, I'm told that sometimes

18

that is selective so perhaps I should end up giving

it to you. You haven't read it in the transcript?

19

A. No, I haven't.

20

Q. I beg your pardon?

21

A. No, I haven't.

22

Q. All right. Well, it's done

23

at a number of times but you are aware of the fact,

if we look up at the diagram on there, there appears

24

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

BB9 to be around Justin Cook's bed, and I think it is just a diagram that was used by Mrs. Christie, evidence from Mrs. Christie that she said that when she went into 418 after midnight that she saw the curtains drawn around the three sides of Justin Cook's bed or cot leaving an opening of about 2 feet or one foot on one occasion I think her evidence was.

Now, is that your understanding as to what her evidence was?

A. Yes.

Q. All right. Now, on the occasions during the course of that shift after midnight, whether or not you were going in to see what was going on in 418 in your capacity as team leader and also in your position of relieving Susan Nelles by the bed of Justin Cook, did you ever see the curtains in that position around Justin Cook's bed?

A. No, I didn't.

Q. And that would be very remarkable, would it not, after midnight on March 22nd when there were no parents around on that ward involving Justin Cook because they had gone back to Owen Sound?



1

2

A. Yes.

3

Q. Yes. And that would be one

4

of the only reasons that you would have curtains

5

around there if the parents wanted to have a quiet

6

private time with their own child?

7

A. Well, it's not the only reason.

8

Q. Well, tell me the other reasons?

9

A. We may have had an overhead

10

light on so that we could see the other children in

11

the room and if we didn't want to disturb Justin

12

you could pull the drapes around the bed so that

the light isn't shining on him.

13

Q. I'm sorry, go ahead.

14

A. That's all.

15

Q. One of the things that we

16

have heard is that above Justin Cook's bed was the

T.V. set up near the ceiling?

17

A. Yes.

18

Q. If one had the curtains around

19

that bed would that impair one's vision of what is

20

occurring on the T.V. set or is the T.V. above the

21

curtains?

22

A. It's above the curtains.

23

Q. I understand. So, whether

24

the curtains were drawn or not drawn the people in

25



1

2

the room could still watch the T.V.?

3

A. Yes.

4

Q. Thank you.

5

And I was wondering, because both

6

Susan Nelles and Janet Brownless certainly indicated

7

in this Commission that they could not recall those

8

curtains being drawn around Justin Cook's bed and

9

you can't and I'm wondering whether you can speculate -

10

not speculate but can you think of any reason why

11

Marianne Christie would come in here and give evidence

12

about that to that effect?

13

A. Only that she might be mistaken.

14

Q. Well, she was very precise,

15

she said I am very certain about that and you say

16

she might have been mistaken?

17

A. Yes.

18

Q. All right. Could you have

19

been mistaken?

20

A. No, I am certain they were not.

21

Q. So, it's for the Commissioner

22

to decide I gather?

23

A. Yes.

24

Q. Now, in any event, Justin Cook
went into terminal events after 3:00 p.m. and finally
died, at least according to Exhibit 383, at 3:45 and

25



B12

1

2

you participated in the last of the 29 resuscitations
that were unsuccessful by your team.

4

A. Yes.

5

Q. And that was an upsetting

6

occasion?

7

A. Yes.

8

Q. You were surprised with the

9

baby's death?

10

A. Yes.

11

Q. He was not expected to die on

your shift?

12

A. No.

13

Q. All right. And one of the

14

things that I was intrigued by your evidence, and

15

this was in response to Mr. Hunt's questions, it is

16

at Volume 134, page 1002 and about the dealings

17

that you felt or what you felt the team was doing

18

at the time of the arrest and I was intrigued by

19

your comment on page 1002 where you said, when

Mr. Hunt was asking you questions:

20

"A. I don't know if it was wanting

21

to take charge. I got the surge of

22

confidence because we became very

23

familiar with what was expected of us

24

during an arrest situation and every

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

"member of the team knew what to do,
and we functioned as a team, and we
functioned very well during emergency
situations, so the confidence came
that I knew my girls or the girls on
the floor would cope and we would get
through this."

Now, ma'am, after 29 straight losses
of children how can you say that you would have a
surge of confidence in dealing with arrests?

A. We had a surge of confidence
in dealing with emergency situations.

Q. But in each case the emergency
resulted in the death of a child. How would you
gain confidence as a result of 29 straight misses?

A. Well, we did our job.

Q. Well, you say that in that
answer, you say your team worked very well. Are you
saying that someone didn't work very well to save
those babies? I don't understand.

A. No, I am not, I am not saying
that at all.

Q. Well, when the 29th one had
been completed when Justin Cook was dead did you
really feel that you were dealing well with emergencies,



1

2

dealing well with arrests, did you have confidence
in you and your team that they were doing very well
for those babies in those circumstances; did you
really?

5

6

A. Yes, I did.

7

8

Q. Now, some rather unusual
events took place after that baby died did they not?

9

A. Yes.

10

Q. Something that had never
occurred on the other 28.

11

A. Yes.

12

13

Q. Dr. Fowler arrived. That was
rather unprecedented that early in the morning?

14

A. Yes.

15

16

17

Q. Dr. Jedeikin said, nurses,
please leave the room alone it must remain secure,
do not clean up anything and what had been started
as a cleanup was stopped.

18

A. Yes.

19

20

21

22

23

24

25

B14



1

2

Q. Dr. Jedeikin said I want
some syringes?

3

4

A. Yes.

5

Q. And he asked you to have them,
or somebody else, and you got them in any event?

6

A. Yes.

7

Q. And Dr. Jedeikin, to your
knowledge, took tests and took control of the IV line,
and took samples from the IV bag and the buretrol
and the line itself?

10

A. Yes.

11

Q. And Dr. Jedeikin also took a
post mortem blood sample?

12

13

A. Yes.

14

Q. Now, if I look at Volume 133,
page 791 through to page 794, there is a definite
suggestion in that evidence before this Commission
that you were not present when the post mortem blood
sample was taken. Do you remember giving that
evidence to Mr. Lamek?

16

17

18

19

A. I can't recall that specifically.

20

Q. Well perhaps I will read it
to you, page 793:

21

22

"A. I went in just shortly after
that to see what they wanted the

23

24

25

CC
1/cr



1

2 2

"syringes for.

3

Q. Yes.

4

A. I had asked Janet and she said,
I don't know. They just asked me to
get them.

6

Q. So you went in to find out,
and what did you see?

8

A. That Dr. Jedeikin was taking
some samples from the IV bags and the
tubing. They were already in the green
garbage bags.

11

12

Q. The tubing was in the green
garbage bag?

13

A. Yes.

14

15

Q. All right. Did you see him
taking any blood samples from the body
of Justin Cook?

16

17

A. No. I can't remember that
today."

18

19

Does that refresh your recollection
as to what you said on April the 19th before this
Commission under oath?

20

21

A. Yes.

22

23

Q. Now, ma'am, do I detect from
that that you may have some difficulty in recalling

24

25



3
1
2 the events of the death of Justin Cook and taking of
3 post mortem blood samples?

4 A. I can't recall that.

5 Q. All right. Perhaps I can
6 refresh your recollection. In Volume 4 of your
7 evidence at the Preliminary Hearing, back in the month
8 of February, January or February 1982. Starting at
line 10, page 812:

9 "Q. Now, did you have any part in
10 preparing those two summaries by Susan
11 Nelles."

12 And we are talking about the nursing notes, all right:

13 "A. I may have helped her I can't
14 remember. I am sure I told her how the
15 baby was, when I fed the baby and if he
did settle.

16 Q. Do you remember seeing her
17 write that in that chart or on that
18 progress note?

19 A. No I don't. I was very upset
20 after Justin Cook had died.

21 Q. How did Susan Nelles seem after
22 Justin had died?

23 A. She was quite upset as well.

24 Q. Where were you after he died?
25



1

2

"A. I went to the back of the
nursing station with Bertha Bell.

3

4

Q. What was done about cleaning
up the room where Justin had died and
cleaning him up?

5

6

7

8

9

10

11

12

13

A. We were advised by Dr. Jedeikin
not to remove anything from the room,
to leave the baby alone for a few
minutes. He had asked for some syringes.
I really wasn't involved at that point.
He was talking to Susan and Janet
Brownless, and Janet Brownless helped
out getting him these syringes.

14

15

16

17

18

Q. Susan Nelles and Janet Brownless?

19

20

21

22

23

24

25

A. Mm-hm. Dr. Fowler was called
in after, just before Justin had
arrested and Dr. Jedeikin and him did,
took some blood samples and samples of
the IV line.

Q. Dr. Jedeikin and Dr. Fowler
took some blood samples?

A. They took some blood samples
from Justin Cook.

Q. Did you see where they took
them from?



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

"A. From the sternum.

Q. From the chest?

A. Yes.

Q. And where else?

A. And then they took samples of
IV fluid intravenous fluid from the
tubings.

Q. All right, and did you see
where in the tubings they took the
samples?

A. No, I did not."

Do you recall being asked those
questions and giving those answers under oath at
the Preliminary Hearing, ma'am?

A. Yes, I did.

Q. Does it refresh your
recollection?

A. Today I can't recall being
in the room when the blood was taken.

Q. Well --

A. I do recall getting the inter-
cardiac needles.

Q. Well, whether you can recall
it today, two years ago you recalled blood being
taken from the sternum or chest of the baby?



1

2

A. Yes.

3

Q. Which is a rather dramatic

4

act?

5

A. Yes.

6

Q. You have never seen that occur

7

before? A post mortem blood sample being taken from
a baby on Ward 4A or 4B, is that not correct?

8

A. That's correct.

9

Q. And you remembered it in

10

January or February of 1982. Do I take it that

11

for whatever reason you forget it now, but are you
prepared to adopt your evidence back in January or

12

February of 1982?

13

A. Yes.

14

Q. Now that was an unusual event,

15

the taking of the post mortem blood sample. I think

16

your evidence to this Commission, to Mr. Lamek and to

17

Mr. Hunt is that you don't recall being overly

18

concerned with the post mortem blood sample, although

19

as you conceded you were upset at all of the events

20

of that night, and do I correctly paraphrase your
evidence before this Commission?

21

A. Yes.

22

Q. I want to read if I may what

23

others have said as to your condition and what you

24

25



1
2 were like after that post mortem blood sample was
3 taken. Volume 125, and this is the evidence of Nurse
4 Susan Nelles starting at 8464:

5 "Q. We have heard as well that
6 after Justin Cook died, and you have
7 indicated that a blood sample was taken
8 from Justin Cook after he died which
9 was unusual --

10 A. I did not remember that but
11 again that appeared in my notes so that
12 is the most accurate.

13 Q. So you are prepared to accept
14 the accuracy of that?

15 A. I certainly remember the
16 samples being taken from the intra-
17 venous bags and what not.

18 Q. That of itself was an unusual
19 occurrence?

20 A. Yes, it was unusual.

21 Q. And we have heard that Phyllis
22 Trayner was very agitated at the sample
23 being taken from Justin Cook after he
24 died and concerned about it to the
25 point of demanding an explanation for
it, and very upset at not receiving an



Trayner, cr.ex.
(Percival)

1

2

"explanation. Did you notice that
reaction in her?

3

4

A. Yes, I did.

5

Q. Did you share the same type
of concern that she had about the sample
being taken?

6

7

A. It did not concern me in an
undue fashion, no.

8

9

Q. Were you puzzled by the fact
that she was so agitated that there
be an explanation for the sample having
been taken?

10

11

12

13

A. I wasn't puzzled by it, but
I think I wished that she would stop
going on about it."

14

15

Now, do you remember, are you aware
of the evidence that Susan Nelles as to what she
saw you do, what she heard from you about the post
mortem blood sample contained in that evidence?

16

17

18

A. Yes.

19

20

Q. Does that surprise you, that
you kept going on about it? You don't remember going
on about it I gather?

21

22

A. Yes, I don't.

23

Q. All right. Let's take Liz

24

25



CC
DM/cr 1

9 2

Radojewski in Volume 112, and as I recall the head nurse came on at about 7 o'clock. You have told us that she was the acting nurse and supervisor that weekend, so she was expected to come on at 7 o'clock even though as head nurse she did not traditionally work on Sundays?

7

A. Yes.

8

Q. And her evidence at Volume

9

112, page 5389, Mr. Commissioner:

10

"Q. Well, whatever occasion it occurred, what were you told about the taking of blood samples from Justin Cook?

11

12

13

A. I was told that after the baby had been pronounced dead that Dr. Jedeikin had come back into the room, taken some blood and taken a sample of IV fluid.

14

15

16

17

18

Q. Were you told why he had done so?

19

20

A. No.

21

Q. Who told you that he had done so?

22

A. Mrs. Trayner.

23

Q. Did she tell you at the same

24

25



1

2

"time how much blood he had taken?

3

A. I don't recall that I knew how much.

4

5

Q. What was her reaction to the fact that Dr. Jedeikin, so far as you were aware, to the fact that Dr. Jedeikin had taken this blood sample or samples?

6

7

8

9

A. Her reaction, she was very upset and extremely agitated, nervous."

10

11

Now again were you aware of the evidence of Nurse Elizabeth Radojewski with respect to what she perceived to be your reaction, extremely agitated and nervous and upset, all about Dr. Jedeikin taking that post mortem blood sample?

12

13

14

15

16

A. I am aware that she said it, yes.

17

18

Q. And you don't agree with it, or you don't remember being that way?

19

20

A. I can remember being agitated. I don't recall being agitated enough only about the blood sample.

21

22

23

24

25

Q. Well let me carry on with one further thing, because it deals with the blood sample in question and I think your evidence in Volume 133,



11

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

page 801 is that after the arrest you never did see or did speak to Lynn Johnstone the night nursing supervisor?

A. I don't recall seeing her after the arrest, no.

Q. Well, I just want to end up making sure, I don't think it was "I don't recall" I think it was more "I don't recall...", I am sorry, I will put it to you. This is Volume 133, page 801 and this again is as a result of questioning by Mr. Lamek, page 801, line 14:

"Q. Do you remember that Mrs. Johnstone came back to the ward towards the end of the shift?

A. I don't recall that, no.

Q. You don't recall seeing her?

A. No.

Q. You don't recall any conversation with her?

A. No, I don't."

Do you recall giving that evidence?

A. Yes.

Q. I want to read to you if I may the other evidence that deals with this matter from Nurse Lynn Johnstone which is found in Volume



1
2 103 and it involves a discussion that she had in
3 the corridor at about 5 or 6 o'clock after Justin
4 Cook's death, after the drug sample was taken, and
5 what you said. Lynn Johnstone at page 347 of that
6 volume said this:

7 "Q. All right. Now did you later
8 in the shift some time after 5 o'clock
9 in the morning return to Ward 4A?

10 A. I did go over to 4A to see how
11 the nurses were, to make sure that
12 they were...

13 Q. Okay, what time was it when
14 you went back there?

15 A. I think around 6:30.

16 Q. Shortly before the end of your
17 shift?

18 A. That's right.

19 Q. Shortly before the end of their
20 shift too, obviously?

21 A. That's right.

22 Q. And who did you see there?

23 A. As I was going up the south
24 corridor Mrs. Trayner was coming to-
25 wards me and she seemed very agitated."
Now, she is talking in terms of the



13 2 south corridor, where is the south corridor? Can
3 we see it on the plan there?

4 A. I suppose so.

5 Q. Is it that if that plan
6 was extended downward it would be down towards the
7 bottom of it. If you were going and coming on the
8 south corridor would you meet at the nursing station?

8 A. I suppose so, yes.

9 Q. In any event:

10 "Q. When you say at the south
11 corridor do you mean from the direction
12 of the elevators?

13 A. That's right.

14 Q. Coming up, down this black
15 passage of the corridor there?

15 A. Yes.

16 Q. All right, you saw Phyllis
17 Trayner. Where was she?

18 A. She was walking towards me
19 in that south corridor.

20 Q. Yes.

21 A. And she seemed very agitated
22 and I asked her what was wrong and she
23 said why did Dr. Fowler take so much
24 blood from Justin Cook and I said I
25



Trayner, cr.ex.
(Percival)

14

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

"didn't know and she was very insistent on why did he take so much and what was he looking for and I just said to her I did not know, that she should have asked him if she was that concerned.

Q. Had you been aware that blood had been drawn from Justin Cook both during the arrest and following the arrest?

A. I knew that blood had been drawn during the arrest because it is always done but I did not know until she told me that there had been more blood taken from the child after the arrest.

Q. All right. She appeared concerned you say about the volume of blood that had been taken?

A. That's right.

Q. Did you ask her how much had been taken?

A. I asked her how much and she said 50 cc."

Now does that refresh your recollection of having seen Lynn Johnstone in the south corridor



1

2

at about 6:30 after Justin Cook died?

3

A. No, it doesn't.

4

5

6

7

Q. Do you recall, because you have said and sworn under oath that you saw the post mortem blood sample being taken from the sternum or the chest of this child. Do you recall it being taken in such large quantities as 50 cc?

8

A. I can't recall.

9

10

11

Q. Do you agree with me that that is a very large blood sample to be taken from anyone whether before death or after death?

12

A. Yes.

13

14

15

16

Q. In any event you have no recollection for this Commission about that incident?

17

A. Not --

18

19

20

21

22

23

24

25

Q. Other than what you have told us?

A. That's correct.

THE COMMISSIONER: Mr. Percival, I just noticed this, the statement, are you intending to make that an exhibit?

MR. PERCIVAL: I don't know, I am content if Mr. Thomson is, in accordance with the rules, I wasn't proposing to because I wanted to only use it for that limited purpose. It is up to



1
2 Mr. Strathy, if Mr. Strathy does not wish it I am
3 content not to have it put in.

4 MR. STRATHY: I don't see there is
5 any particular need to, Mr. Commissioner.

6 THE COMMISSIONER: No.

7 MR. STRATHY: I will take it back
8 then.

9 THE COMMISSIONER: Yes, take it back
10 if you will.

11 MR. PERCIVAL: Thank you.

12 THE COMMISSIONER: You were querying
13 a break. I would think any time that would suit you
14 after 3 o'clock.

15 MR. PERCIVAL: Thank you.

16 Q. Well, ma'am, and before we
17 get off the question of the post mortem blood samples
18 and for completeness; at Volume 4, page 845 when you
19 were being questioned about the Monday night meeting,
20 this deals with the post mortem blood sample, and
21 this is your evidence under oath, Volume 4, page
22 845, line 12:

23 "Q. All right. Do you recall
24 anything that Susan Nelles said at
25 this meeting?

A. Hm-mm. Susan Nelles was, she



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

17

16

17

18

19

20

21

22

23

24

25

"was bewildered as with all of us that something that we had no answers to. I myself was very upset that Dr. Jedeikin was running around taking samples the night before, of Justin Cook and not telling me anything, or not explaining as to why all this was being done. Why Dr. Fowler was coming in at 5 in the morning because I had to report to Liz. I mentioned that at the meeting that nobody was saying anything. We asked questions and we weren't getting any answers."

Does that refresh your recollection again of whether or not you were upset or not upset about the taking of post mortem blood samples?

A. I can't recall specifically being upset about the blood. I do recall being very upset about the whole events of the night. What Dr. Jedeikin and what he was doing were two different things and we had no answer, just a lot of confusion.

- - -



DD/EMT/LN

1

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Now I turn to what happened at the end of the shift then when there was a meeting as you have described in Volume 133, pages 804 to 806 in which is commonly - or it may not be commonly described but around here it is called the dirty utility room. Is that the correct terminology?

A. Yes.

Q. All right. And that was the way it was known three years ago in March of 1981?

A. Yes.

Q. This was an area which was in close proximity to the nursing station which was used from time to time for nurses to meet informally as they come on shift and go off shift? Is that fair?

A. No.

Q. Well, tell me what it was used for.

A. It's a -

Q. Aside from dirty utility I mean.

A. That is what it is used for.

Q. All right. Why did you end up there?

A. I'm not sure why - I think we were still cleaning up Justin Cook's room at that time, and that is where we take all the garbage and I guess everybody met there.



DD2

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. All right. In any event your recollection is that on that occasion - was that before or after you gave report?

A. I thought it to be before.

Q. All right. So it would be before 7 or close to 7.

A. Yes.

Q. Your recollection at 804 to 806 is that there were four people in the room besides yourself; Janet Brownless, Elizabeth Radojewski, Susan Nelles and Bertha Bell. And your recollection is that those were the only ones who were present? That's what you said.

You have a recollection of somebody else being present?

A. I thought Marie Mandal was there.

Q. All right. So there would be six of you in the room?

A. Yes.

Q. And at that time at page 805 you proceeded to tell Mrs. Radojewski about all of the events of the night involving Dr. Costigan, Dr. Mounstephen, the digoxin being locked up, the double signing and your expectation that a pink memorandum would explain it all if you got it?



DD3

1

2

A. Yes.

3

Q. All right. Do I take it that

4

at that time and coming off that shift and after
another baby death, you were upset?

5

A. Yes.

6

Q. Susan Nelles was upset?

7

A. Yes.

8

Q. Liz Radojewski was upset?

9

Do you recall ~~that~~ all three of you were crying at
that point?

10

11

A. I can't recall, no.

12

Q. Well, Elizabeth Radojewski at

13

Volume 112, 5387 to 5388 indicates that she was
crying and you were quite agitated, to use her

14

expression. Do you remember being quite agitated?

15

A. Well, as I explained I was

16

agitated through the night.

17

Q. All right.

18

A. And more in a state of confusion

19

as well.

20

Q. Well, someone else described you

21

in relation to what she saw, and that is Meredith

22

Frise, and perhaps I could deal with that in some

23

detail because Meredith Frise gave evidence in these
proceedings at Volume 109, page 4778.

24

25



DD4

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

First of all, were you aware of the evidence that was given by Meredith Frise before you came here to give evidence yourself?

A. I was aware of going to the drug store for -

Q. Yes, well, were you aware of the fact that she was also in the dirty utility room that day coming on shift as you were going off shift?

A. She may have been.

Q. All right. At 4778 she says:

"A. Oh, maybe 7:00.

Q. All right. And when you came to the dirty utility room on that particular morning after Justin Cook had died, who was present in the room.

A. Liz Radojewski, Susan Nelles, Phyllis Trayner. I was called to come by Marie Mandal and those people were in the room.

Q. All right. And you say you were called to come. For what purpose, what did she say to you.

A. She said come, Meredith, and listen to what Liz has to say.

Q. All right. And when you came in



DD5

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

the door was Marie Mandal there, Phyllis Trayner, Susan Nelles and Liz Radojewski.

A. Yes.

Q. All right. Can you tell me what their physical state was, what observations you made of them at that time.

A. From what I can best recollect is that Liz Radojewski was crying, she seemed quite upset.

Q. And what about Phyllis Trayner?

A. I don't recall anything about Phyllis Trayner at that point.

Q. Was Marie Mandal coming on shift with you at this point.

A. Yes, she would have been."

Carrying on at the bottom:

"Q. All right. Well what was being said at that meeting in the utility room on that morning after Justin Cook died.

A. What was being said was something regarding the Cook baby and that Liz was upset and why this child had died.

Q. All right. And was that being expressed in your presence?



DD6

1

2

A. From what I can recollect, yes."

3

And down below:

4

"Q. All right. Well, after Liz Radojewski said that was there any response from anybody else in the room, this enquiry about why Justin Cook had died.

8

A. Not that I can recall."

9

Do you recall Meredith - do you recall Liz Radojewski asking you and asking Susan Nelles why did Justin Cook die? Do you remember that being asked of you.

12

13

A. Well, she always asked us what had happened and we gave her the sequence of the events that night.

14

15

16

Q. Did you have any explanation why this baby had died who was under constant nursing care by you and Susan Nelles?

17

18

A. No, I didn't.

19

Q. You had no explanation at that time?

20

21

A. I think we told her that he went into a severe blue spell.

22

23

Q. Was that your perception at that point that it was a blue spell that the baby did not

24

25



DD7

1

2

survive from?

3

A. I can't really remember.

4

Q. Well, knowing as you did that

5

digoxin had never been prescribed for that baby I

6

gather you didn't think about whether it was digoxin

7

that had killed that child.

8

A. No, we didn't.

9

MR. PERCIVAL: I am going to deal with

10

the events right after that. It is probably an

11

appropriate time, and I think I am in good shape.

12

THE COMMISSIONER: Yes. All right 20
minutes then.

13

--- (Short recess)

14

--- (Upon commencing)

15

THE COMMISSIONER: Miss Cronk, do

16

you want to say something about your memo or do you
want me to?

17

MS. CRONK: Feel free to, sir.

18

THE COMMISSIONER: Well, I don't know

19

what it is.

20

Miss Cronk has made a terrible error.

21

MS. CRONK: That's right and I think it

22

would be better if I announced it.

23

THE COMMISSIONER: So I think she had

24

better make her own confession. What is it?

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MS. CRONK: Dr. Kauffman is scheduled to testify next Wednesday and I am informed reliably that is May 2nd and not May 3rd.

THE COMMISSIONER: All right.

MS. CRONK: So lest there be any confusion....

THE COMMISSIONER: Yes. All right.

MR. PERCIVAL: That's what they call a mayday announcement, Mr. Commissioner.

THE COMMISSIONER: All right, yes, Mr. Percival?

MR. PERCIVAL: Q. Mrs. Trayner, I want to deal with the events after you had come out of the dirty utility room, and as I understand your evidence at Volume 133, 807 and 808 and later clarified by Mr. Hunt in cross-examination of you in Volume 135 on page 1073, Mrs. Radojewski even though she was the weekend supervisor and the nursing supervisor took the time to say to you and Susan Nelles "Come on, let's meet in the coffee shop. You come and relax and wind down after this last baby death." Do I take it that's what your evidence is?

A. Yes.

Q. And you had given her some



1
2 considerable information in the dirty utility room
3 as to the events surrounding what occurred with
4 respect to the death of Justin Cook?

5 A. Yes.

6 Q. And the locking up of digoxin
7 and all of that. So that had been expressed to
8 her earlier even before you got to the coffee shop?

9 A. Yes.

10 Q. All right. As I see your
11 evidence in 807 and 808 when you were questioned
12 by Mr. Lamek:

13 "Q. And for how long did you sit
14 having coffee?

15 A. It was about 20 minutes, half
16 an hour, we were both very tired.

17 Q. Did you talk about the events
18 of the night?

19 A. I don't think so.

20 Q. Do you recall any discussion
21 between the three of you as to what
22 these events could mean?

23 A. The only conversation I remember
24 is Liz asking Susan did she write
25 down everything about Baby Pacsai,
did she write her notes and Susan



1

2

"saying yes, and then we talked about
the weather."

3

4

5

6

7

8

9

10

11

12

Okay. Now I want to take you to
this position, that at that point if other evidence
is accepted Elizabeth Radojewski was crying, was
upset, with respect to this last baby death and
she was the head nurse on these wards that had, by
my recollection, on March 6th the death of Baby
Warner, March 7th the death of Baby Hines, March
8th the death of Baby Gionas, two deaths, Manojlovich
and Pacsai on March 11th, March 12th Inwood, March
17th Garnder, March 20th Miller, March 21st Cook.

13

14

15

16

17

18

19

Do I take it that when you went for
coffee that surely you must have been talking about
something more aside from only one of those 9 or 10
babies that had died in similar circumstances on
your team in the long night shifts in the course of
the past two weeks. Surely you must have talked
about at least one of those other babies aside from
Baby Pacsai?

20

21

22

A. I don't believe we did talk
about anything else unless we brought up Cook again.
I don't recall anything else.

23

24

25

Q. Well, you can't really be
serious, ma'am, and I don't know whether that was



1
2
3 a throwaway line or not. Surely you can't say to me
4 that after those series of traumatic events that you
5 came down to going to the coffee shop and talking about
6 weather.

7 Is that just a figure of speech or
8 did you really talk about the weather?

9 A. We did talk about the weather.

10 Q. And that was important to you
11 at that time?

12 A. It was a time to go down and
13 just have a coffee and relax.

14 Q. But that was important to you
15 at that time after 10 deaths in 14 days? It was
16 important to talk about the weather with your head
17 nurse?

18 A. At that time, yes.

19 Q. All right. You found that
20 relaxed you I gather. Winds you down?

21 A. Yes.

22 Q. Then on Sunday a series of
23 events occurred that you have told Mr. Lamek about,
24 and it is in Volume 134, and as I understand the
25 sequence of events Miss Janet Brownless called you
about 5 o'clock and at 5:30 Mrs. Radojewski called
you?



1

2

D12

3

A. Yes.

4

Q. And then you called Bertha
Bell between 5 and 6 o'clock?

5

A. Yes.

6

7

Q. And at about 12 midnight
you took the initiative and called Bertha Bell at
the Hospital to see what was going on?

8

9

A. I believe so.

10

11

12

13

14

Q. All right. Whether it was
from Mrs. Radojewski at 5:30 or from Bertha Bell
at midnight I gather that what was conveyed to you
was that something rather strange, even more strange
than the events that had occurred on the night
Justin Cook died, were occurring at the Hospital?

15

16

17

18

You were then aware in the evening
of Sunday evening as a result of discussing with
Bertha Bell and Liz Radojewski that supervisors
had been on the ward since you had left at 7 o'clock?

19

A. That didn't come from Liz
Radojewski.

20

21

22

23

24

25

Q. (Did it come from Bertha Bell?

A. It may have, yes.

Q. Well, --

A. That night.

Q. Yes, that night.



1

2

A. Yes.

3

Q. I am talking about that night.

4

A. Yes.

5

Q. That night you were aware of

6

the fact that supervisors were on the ward, that

7

keys had been confiscated from the nurses, the

8

team leaders, that there were no transfers. There

9

were transfers out of 4A and 4B and no new admissions.

10

You were aware of that, weren't you?

11

A. I can't remember if it was

the Sunday night or the Monday, but --

12

Q. But you were made aware at

13

least whether or not it is Sunday night or early

14

Monday morning you are aware of the fact that the

15

nurses are supervised in their administration of

16

medication to any baby that was alive on those wards

17

at that time?

A. Yes, I was.

18

Q. You were also aware I suggest

19

to you that every baby that was still alive on that

20

ward commencing at about 8 or 9 o'clock on Sunday

21

morning was having digoxin tests conducted on them;

22

isn't that true? That is something you haven't

23

been asked about, but you knew that, didn't you?

24

A. I think we knew - I think I

25



1

2

knew that on the Monday night meeting at Liz' place.

3

4

Q. You mean you didn't know before the Monday meeting that every baby on that ward was having digoxin tests performed on it on the Sunday after you left?

5

6

7

8

A. I'm not sure. I may have.

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Well, the combination of all of that and the combination of what occurred in Justin Cook's - at the time of his death and the post mortem blood sample and everything, do I take it that under the circumstances quite apart from strange events occurring on the night that Justin Cook died, this was really unbelievable? What was big to you when the digoxin was being locked up was something a lot more than you had contemplated even then. Is that correct?

A. Well, that would be fair, yes.

A. Yes.



1

26apr84
EE
BMcrc

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Then do I take it that the next Monday afternoon you convened, whether intentionally or otherwise, a meeting of a number of the nurses on either 4A or 4B at your apartment?

A. Yes.

Q. And it was Marie Mandal, Meredith Frise, Mary Cooney, Mary Jean Halpenny, yourself and Janet Brownless. I gather there were about six of them there?

A. Yes.

Q. And you were asked about this in Volume 134, page 855. You were asked as to what you talked about. At the top of 857 you talked in terms, you ordered pizza and wine. Were you talking about the events of the Hospital, and your answer was:

"A. To the best that I can remember, I think Mary Jean Halpenny was off for a couple of days and when she arrived, Marie Mandal was filling her in on what had happened.

Q. Yes?

A. What was going on, and I think that was about the extent of it. And then we went on to something else." Now, my reading of the evidence from



EE2

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

your source is the fact that all of these girls started to arrive at eleven o'clock and you didn't leave until after 6:00 to go to Nurse Radojewski's home for this meeting?

A. Right.

Q. So, we've got seven hours and you've got six, if not seven, nurses there all on this shift in Wards 4A and 4B and surely, Mrs. Trayner, you must have been discussing a little bit more than that one occasion where Mary Jean Halpenny wondered what was going on. Surely you must have been talking about 29 deaths, surely you must have been talking about the patterns that you said you recognized in early March, surely you must have been talking in terms of the big investigation that was then going on.

You will forgive me but it defies my imagination that aside from a brief discussion with Mary Jean Halpenny that for seven hours you girls didn't talk about the events at the Hospital. That's a little bit much, isn't it?

A. Well, it may seem like a lot to you but at the time it wasn't. We had discussed it when the girls came over at 11:00 and Marie Mandal was still quite upset from the events that happened



EE3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

on the Sunday. We had discussed that, she had told me what was happening on the floor and Liz Radojewski called, I thought around 2:30, two o'clock. She sounded much better on the phone and told us that everything was going to be okay and we would have a meeting at her place.

Q. Well, let me talk about this. At this point in time and at this meeting where you had seven nurses around, let me think about the things that were unusual and let me see if you agree that everybody knew about these things that afternoon. There had been 29 deaths in the nine months that you are concerned with, they had always occurred in the night shift, always your team, always after the break, consistent terminal events, Pacsai inquest forthcoming, the digoxin lock-up, samplings of the IV, the post mortem blood samples, Dr. Fowler coming in at five o'clock, a biochemist being called in at 5:30 on the Sunday morning, it was the ninth death in eight nights, the supervisors were in, the keys were confiscated, the drugs were being supervised, no transfers and no new admissions, digoxin tests on every surviving baby.

Now, tell me, are you seriously suggesting that those rather bizarre events, rather



1

EE4 2 bizarre circumstances that involve any nurse in any
3 hospital in the world, surely they were discussed
4 amongst the seven of you who were so intimately
5 involved with it, surely they were?

6 A. I don't believe they were.

7 Q. Do you recall that afternoon
8 discussing about all of the deaths that had occurred
9 and whether or not you as a nursing team had
10 missed something? Do you recall talking about that?

11 A. Not really, no.

12 Q. Meredith Frise was there
13 and she was examined by Mr. Lamek at some length on
14 this, and may I read this to you, this is what she
15 said occurred on that Monday afternoon. It is Volume
16 109, 4684, Mr. Commissioner. Her recollection was
17 it was four hours she was there with you.

18 "Q. Four hours is a long time.
19 Can you give me your best recollection
20 of what was discussed during that
21 afternoon at Mrs. Trayner's apartment?"

22 A. From my best recollection they
23 talked about the deaths within the
24 Hospital, so many deaths we had on the
25 floor, not any particular death at
26 all that I can recall. Something to



EE5

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

the effect of the possible Coroner's
inquest on the Pacsai baby."

And then at the bottom of the page:

"Q. As you say you recall that
there was talk about deaths that
had occurred on the floor although
not individual deaths. There was
discussion too of the Coroner's
inquest that was apparently to be
held on the Pacsai child. Can you
remember any other topic that was
discussed during the course of the
afternoon?"

A. I believe that it was dis-
cussed they were, meaning the nurses,
missing something in regard to these
children's deaths, could we help
by preventing them.

Q. Any other topic that you can
now recall?"

A. None that I can recall, no.

Q. Those three topics..."

And then Mr. Lamek went on and discussed each of them.

Do you remember that occurring now
that I have refreshed your recollection with what one



1
EE6 2 participant in the afternoon at your apartment re-
3 called? Does that refresh your recollection about
4 your talking about those things?

5 A. No, it doesn't.

6 Q. So, you don't even recall
7 then as team leader, the only team leader that
8 afternoon at your apartment, enquiring introspectively
9 as to whether or not you and your nursing team had
10 missed anything? You never thought about that, to
your recollection?

11 A. I don't know. We would have
12 discussed maybe Justin Cook.

13 Q. Meredith Frise says, "with
14 these deaths", plural. You don't remember that?
15 You don't recall thinking to yourself, gee, have I
16 missed anything? I'm the team leader of this team,
17 why are we having so many deaths? Have we missed
18 something as nurses? You don't recall that being
discussed with your six other people at your apartment
19 that afternoon?

20 A. No, I don't.

21 Q. Right. May I move on to the
22 events of Monday night when you were made aware then
23 certainly of what was going on. Do I take it that
the series of unusual events that I have just listed
24
25



1
EE7 2 about three or four minutes ago, those were the
3 things that were in your mind and in the minds of
4 many others that were at Mrs. Radojewski's home on
5 the Monday evening, everybody knew about them; if you
6 didn't know about them, somebody told you?

7 A. About the events of the
8 Saturday night, you mean?

9 Q. And the Sunday.

10 A. Yes.

11 Q. And the Monday.

12 A. Yes.

13 Q. So, everybody knew about it,
14 so I gather because it was so unusual that it was
15 all being talked about, that was the purpose of the
16 meeting and seeing whether or not your rights as
17 nurses were somehow being infringed?

18 A. Yes.

19 Q. And you were talking about
20 a series of baby deaths and you were talking about
21 more than just Pacsai and more than just Justin Cook,
22 isn't that true?

23 A. I really can't remember
24 talking about it any more. I do remember Baby Pacsai.

25 Q. Well, do you recall somebody
making comments, whether or not it was - do you remember



1
EE8 2 somebody at that meeting talking in terms of a leak
3 about digoxin having something to do with the death
4 of Justin Cook? Do you remember somebody saying that?
5 A. No, I don't.
6 Q. Well, maybe I will refresh
7 your recollection. Meredith Frise, Volume 17 of the
8 preliminary, Mr. Commissioner, at page 16, where she
9 talks about leaving your house, Phyllis', Question 20:
10 "Q. And how did you get to her
11 house?
12 A. Subway.
13 'Q. Both of you, Marie Mandal and
14 you?
15 A. Yes.
16 Q. Then you drove in Phyllis'
17 car, so it was Marie that was in the
18 back?
19 A. Yes, Marie would have been in
20 the back.
21 'Q. Yes. The three of you were
22 in the car?
23 A. Mm-hmm.
24 'Q. You got to the meeting at
25 Liz' house?
A. Yes.



GE/BM/ak

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Q. Do you recall driving Marie Mandal and Meredith Frise to the meeting at Radojewski's?

A. I recall driving somebody there, yes.

Q. All right.

"Q. Had it already started when you got there or did you get there before it started?

A. I think we were the first group of people but it hadn't started yet.

Q. What was the meeting about?

A. It was about the deaths that had happened on the floor, just talking about malpractice, whether it was a mistake that the kids got digoxin.

Q. Hm-mm, all right. And when you say the deaths of the kids on the floor, there had been two deaths on the weekend, Baby Cook and Baby Miller. Were they discussed at the meeting?

A. There were kids talked about but I can't remember exactly who was talked about.

Q. You can't remember who was



1

2

EE2

3

"talked about?

4

A. Not exactly, no.

5

6

Q. You say 'kids', that's in plural, there was more than one child discussed then?

7

A. Yes.

8

Q. Were these kids that had died?

9

A. Yes.

10

11

Q. Well, what if anything did you say at the meeting, do you recall that, Miss Frise?

12

13

14

15

16

17

18

19

20

A. Mm-hmm. I remember saying to Mary Costello, she was sitting beside me, and I asked her something about digoxin, that there was sort of a leak before, like, we weren't supposed to know about the digoxin and I said to Mary is it the kids, got something to do with digoxin and she sort of looked at me and said 'I can't comment on that'."

21

22

23

Do you recall that interchange occurring between Meredith Frise and Mary Costello at that meeting in your presence?

24

25

A. No, I don't.



1

2

3EE3

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. So, do I take it that it is your recollection today that at the meeting at Radojewski's house that insofar as deaths are concerned the only deaths that you recall discussing was the evidence about Susan Nelles and the Pacsai death and maybe Justin Cook?

A. Well, it would be the events of the Saturday night.

Q. All right.

A. And Justin Cook.

Q. So, I gather then the death of Justin Cook was not something that was an event that was germane to your meeting?

A. Well, it was discussed that he had died and what had happened after.

Q. All right. So, it is the events that happened afterwards were that which were discussed, not the fact that he died or why he died, isn't that true?

A. Yes.

Q. So, you don't recall any discussions such as Meredith Frise said that by Monday night there had been a leak about digoxin having caused the death of these children, you didn't know anything about that?



1

2

A. No, I didn't.

3

Q. Nor did anybody else tell you?

4

A. No.

5

Q. Now, I want to deal with this,

6

you left the meeting on Monday night. How did you

7

leave, did you drive your car back?

8

A. Yes.

9

Q. Did you drive anyone back?

10

A. I may have driven someone to
the subway.

11

Q. Right. You went home and I

12

believe that you had planned at that particular point

13

of going into work on the long day shift on the

14

Wednesday?

15

A. Yes.

16

Q. And at that particular point

17

you were comfortable because you knew that Liz

18

Radojewski was going to go to the RNAO and you thought
that everything was under control?

19

A. Yes.

20

Q. Is that right?

21

A. Yes.

22

Q. And you didn't feel accused

23

at that particular point?

24

A. No.

25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

E5

Q. And you were then satisfied do I take it that as a result of the previous discussion involving the phone call on the Sunday from Nurse Radojewski that really you had been given the pleasure of a day off with pay because of the stress created by the death of Justin Cook. You were satisfied with that at that point on Tuesday?

A. Well, as I say, it was still surprising but I accepted it.

Q. All right. Now then when you got the next phone call though some time on the Tuesday afternoon or even Tuesday evening from Liz Radojewski the alarm bells started going off, did they, because of the tone of her voice?

A. Yes.

Q. And the tone of her voice was very firm?

A. Yes.

Q. And it was 'you are not coming in tomorrow'.

A. Right.

Q. And did she say 'your team is not coming in tomorrow'?

A. Right.



1

2

3

Q. Did you say why?

4

A. Yes.

5

Q. And what did she say?

6

A. I can't say any more than that.

7

Q. I can't say any more than that.

Did you press her?

8

A. Yes.

9

Q. And what did she say, how did

10

you press her, tell me what you said to her?

11

A. She had phoned and said that

12

she was calling to let me know that we would not

13

be able to return to work tomorrow, and I said why

14

and she said, well, I really can't go into it now,

15

suffice it to say that you can't come in tomorrow.

16

I said, what's going on and she said your team is

17

off, there's going to be a meeting held at the

18

Hospital about 10 o'clock in the morning and I may

19

know more at the end of the meeting. She asked me

20

what I had planned to do tomorrow. She told me

21

then that she would call me after the meeting, she

22

thought that would be at noon some time. She

impressed upon me that she wanted me to be at home

on Wednesday.

23

Q. Wednesday morning?

24

A. She wanted me to be there by

25



1

2

12:00 because she thought she would be phoning at
12:00 and she had said she didn't want to be phoning
around the city looking for me, so, to please be
home so that she could call me. She told me that
there would be a press release.

6

Q. Yes.

7

A. I said what kind of a press
release.

8

9

Q. Thank you, I was going to
ask you that because you were never asked. I would
have thought that would be a logical question and
you did ask her. What sort of press release?

10

11

12

A. Yes.

13

14

Q. First of all, before we get
to that, did you ask her what sort of a meeting at
10 o'clock and who was to be in the meeting?

15

16

A. She just said it was a
meeting with Hospital officials.

17

18

Q. Hospital officials, is that
as far as it went?

19

A. Yes.

20

Q. Did she say anything about
the coroner?

21

22

A. No, not that I can recall, no.

23

Q. Did you think that it was

24

25



E8

1

2

3

4

5

6

the investigation that you had thought that was
going on on Saturday night was the investigation
that was going to culminate in this meeting on
Wednesday morning with the Hospital officials, did
that come to your mind?

7

A. Well, I thought it had something
to do with the events of Saturday.

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25



FF/DM/LN

1

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Yes. Well, that it was an investigation.

A. Yes.

Q. And you were satisfied that that was an ongoing investigation?

A. Yes.

Q. And when she said "hospital officials" you took it to mean that the investigation team was going to meet?

A. Yes.

Q. And then you asked her about what press release, tell me what her response was?

A. She sounded like she was starting to cry, her voice was a little shaken. She said "it's not going to be very good".

Q. "It's not going to be very good". Well, having heard that quote "it's not going to be very good", did you ask her what do you mean "it's not going to be very good"?

A. Yes, I did.

Q. Did she say it just like that "what do you mean".

A. Yes.

Q. What did she say?

A. "I can't say any more".



FF2

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Q. Was that the end of the discussion?

A. She said I will call you tomorrow, please be home when I call and I will let you know tomorrow if you can return to work on Thursday.

Q. It's not going to be very good. Well, do I take it on that that you felt you were being accused and members of your team were being accused?

A. I knew at that time that they were looking at our team because it was our team that was off. I was very upset because Liz had said something about "what's going to happen to us", and that it wasn't going to be very good and that she wanted me to be almost by the phone, waiting.

Q. Or be at home in case somebody came?

A. I don't --

Q. You didn't take it that way?

A. She never said that and I didn't think that.

Q. You may not have thought it then but you thought it the next morning I gather when the officers walked in the door?

A. Yes, when they came I knew.



FF3

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Q. In any event, I want to know, is that all that you can recall of that discussion on the telephone with Nurse Elizabeth Radojewski, your head nurse? Is there anything more you wish to tell me or that you can recall at this point?

A. Just that she was asking if I had heard from Susan and I had told her not today.

Q. All right.

A. And she was having trouble contacting Susan and that she would contact her, and that if I had heard from Susan to ask Susan to call her if she had not be able to contact her.

Q. When you got off the phone, were you scared?

A. I was a little - well I was upset.

Q. Were you scared, were you frightened?

A. Well - yes.

Q. And later that evening you phoned Susan Nelles, didn't you?

A. I phoned her shortly after I got off the phone with Liz.

Q. And what did you tell her, what did you say to her?

A. Well first of all I had asked



FF4

1
2 her if Liz had called her and she said yes. Susan
3 said "I wonder what is going on". She had told me
4 that Liz had told her, it was basically the same
5 story that Liz had told me and she said it only
6 involves our team. I said, I know. She told me that
7 she was going to talk to, I think it was Alison one
8 of her room-mates who was a law student, that evening
when she got home.

9 Q. Is that all that you can recall
10 in relation to your discussion with Susan Nelles,
11 that you can recall at this time?

12 A. Basically, yes. She was going to
13 ask her something about the coroner's inquest as well.

14 Q. Did you say to her "I'm frightened
15 I'm scared, they are pointing the finger in our
16 direction, I feel like they are accusing us or
something".

17 A. I don't know if I used those
18 terms. I may have said, you know, look it's our
19 team, it is only our team that is off and we can't
20 go in and we have no answer.

21 Q. Well let me put to you what
22 Susan Nelles said about that discussion on the
23 telephone that you had with her, and this is at
24 Volume 126, Mr. Commissioner, at page 8698.
25



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

"Q. And after that telephone call
you received a telephone call
from Phyllis Trayner, did you not?

A. Yes, I did. I believe it was
the Tuesday.

Q. All right.

A. As I say, I couldn't remember
whether it was the Monday or the
Tuesday.

Q. In any event she called you.
What did she say to you.

A. She was very concerned that our
team was being isolated and that they
seemed to be pointing a finger in our
direction.

Q. Who is "they"?

A. The investigation.

Q. All right. And when you say
"isolated" you also mean accuse you?

A. No, I do not."

And then I pointed out to you what she
had said in Exhibit 394 where in her Counsel's
handwriting as a result of what she said;

"Phyllis called me -- she was really
upset - she said she was scared - felt



FF6

1

2

they were trying to accuse us."

3

A. Right.

4

Q. Did she say that to you?

5

A. Yes, she did.

6

Q. Did you agree with it?

7

A. No, I didn't."

8

Does that refresh your recollection of that discussion you had with Susan Nelles on the Tuesday evening?

10

A. I really can't remember what I

11

said. I do remember being upset and being scared that it was our team. I was anxious that, what this press release was.

13

Q. Yes.

14

A. That Liz had sounded so upset

15

about that it wasn't going to be good.

16

Q. Wasn't going to be good and you

17

interpreted that good for you?

18

A. I didn't know what I interpreted.

19

I just knew that it wasn't going to be good.

20

Q. All right.

21

A. Liz was upset and our team was off,

22

there was a possibility that we might not even be

23

allowed back to work on the Thursday; and Liz being

24

so insistent that I be home to receive this phone call.

25



FF7

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Q. Mrs. Trayner, Miss Nelles, was she saying here is the fact that you were frightened and scared and you felt that they were trying to accuse you, and that you said that to her but she didn't agree with you. Do you remember Nurse Nelles saying to you "oh don't be silly Phyllis they are not trying to accuse us, we have nothing to worry about", do you recall that was the impression she gave to you as a result of that discussion?

A. No, I don't.

Q. Did she agree then with you that she felt being accused, that she felt being vulnerable, being threatened?

A. Yes. I can recall her feeling that, because she wanted to speak to her lawyer.

Q. All right. I'm sorry, did you express the other thing that maybe you should be talking to a lawyer at that point?

A. No. I think she was going to see her law student about the coroner's inquest.

Q. Yes.

A. I didn't know anything about that. If we needed to then I was going to get the information from Susan, you know, if we needed anything. I didn't feel we needed a lawyer.



1

2

Q. All right.

3

A. I also remember her saying to me

4

"how did Janet Brownless get dragged into this

5

because Janet really wasn't a part of our team",

6

like she worked a lot but now all of a sudden Janet

7

was team and she was also not allowed to come in to
work.

8

Q. In ^{if} fairness, Janet Brownless had

9

been involved in a series of the baby deaths

10

though, culminating in the death of baby Cook.

11

A. Yes, that's right.

12

Q. You knew then as a result of

13

with the one or two or four conversations, whoever

14

it was with, that Janet Brownless, Marianna Christie,

15

Sui Scott, you and Susan Nelles were the five that

16

A. Yes.

17

Q. Until the meeting took place and

18

until the press release was given.

19

A. Yes.

20

Q. And you didn't feel very good

21

about that?

22

A. No, I didn't.

23

Q. So then that after that

24

telephone conversation with Nurse Nelles then I

25

FF8



FF9

1

2

gather there was nothing else that occurred on that
Tuesday night.

3

4

A. No, there wasn't.

5

6

Q. And the next morning your
husband got up and went off to work, and shortly
afterwards two officers came to your door.

7

8

A. Right.

10

11

12

13

14

15

16

17

18

Q. Now I want to deal and come back
to the matter that has troubled me, it is the
beginning here. It involves whether you thought
there was a sequence or a pattern involved. I think
to refresh your recollection as you said to both
Mr. Lamek and myself, that even by March of 1981
with this phenomenal incidence of increasing baby
deaths, long nights, after midnight, your team,
that while there was a pattern you still even up to
the time the police officers walked in the door,
you felt in your own mind that was coincidence and
bad luck.

19

A. Yes.

20

21

22

Q. And that is what you feel now.
I think you put a caveat, in fairness to yourself, and
the caveat was, well, unless somebody was trying to
implicate you, set you up, or frame you.

23

24

25

A. Yes.



FF10

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Q. And back on April 18th of 1982,
in Volume 30, you were being cross-examined by
Mr. Cooper, page 70; and Mrs. Trayner you recall
Mr. Cooper asking you these questions after he had
gone through death after death after death, and this
was after the similar fact evidence had been put to
you and you had answered questions to Mr. Willey
and then Mr. Cooper cross-examined you at line 8
and says:

"Q. If we are going to play with
statistics, Miss Trayner or Mrs. Trayner
I guess that a statistic that we could
toss around might be the fact that
with respect to each night or early
morning that a child died, 24 nights,
24 early mornings, I guess you were on
duty.

A. That's correct.

Q. 24 out of 24 times.

A. Correct.

Q. And with respect to each one
of those children
that we have talked about this morning
is that correct.

A. That's correct.

Q. Doesn't it strike you as being



1

FF11 2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

beyond coincidence that you would be
on duty each night and early morning
that each of those children died.

A. I don't know what you want, is
it more than a coincidence?

Q. Is it more than a coincidence.

A. With those odds, yes, it would
seem like it, yes."

Now that was an opinion that you
expressed under oath in response to a question by
Mr. Cooper in April of 1982. Do I take it that you
felt then and you felt now that it goes beyond
coincidence. There is something more with the odds
that you know existed and knew existed in April of
1982 and now even more so as a result of the report
of the Atlanta Commission. It goes beyond coincidence
and bad luck doesn't it?

A. I don't know, when I answered
that before, you know, 24 out of 24.

Q. Here we are talking about 29
out of 29.

MR. THOMSON: Would you let the
witness finish please.

A. I didn't really know how to
answer Mr. Cooper, it was right there 24 out of 24



FF12

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

and it was more than a coincidence, yes it was,
that was the only answer that I had.

Q. All right. Well let's take it
one step further. Now we are talking about 29 out of
29 and you were on duty. Is it more than a coincidence
more than bad luck. Was someone there, out there,
someone must have been killing those babies, do you
not agree with me?

A. I don't know if those children
were murdered.

Q. One last question and I think it
is an obvious question. On your oath to God Mrs.
Trayner, did you kill any of those babies?

A. No, I didn't.

MR. PERCIVAL: Thank you.

THE COMMISSIONER: I see all your
assistants, Miss Thomson have left.

MS. THOMSON: It would seem that way,
sir. This might be my good chance.

THE COMMISSIONER: Do you want to go
along without them or would you rather wait or
would you rather they earned their pay?

MS. THOMSON: I would rather wait.

THE COMMISSIONER: Yes, all right.
Well, I think we will all rise until Monday at



FF13

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

10:00 o'clock. Does anyone have any doubts Monday
at 10:00 o'clock.

MR. STRATHY: I was just going to
say Mr. Commissioner, if there is any lingering
doubt that we would not be through by the end of the
day on Tuesday, that we should start at 9:30 on
Monday.

THE COMMISSIONER: I don't think so,
when I took the poll this morning it didn't look
that bad. Has anyone decided to double their
estimate.

MR. STRATHY: I'm not sure that Mr.
Shanahan was here this morning nor was Mr. Ortved.
Well they are both pretty snappy people.
They don't take too long.

You don't intend to spend more than a
day, do you.

MR. ORTVED: No Mr. Commissioner.

THE COMMISSIONER: Mr. Shanahan.

MR. SHANAHAN: No sir I won't be very
long.

THE COMMISSIONER: I don't think we
are in any trouble we will start at 10:00 o'clock
If we find during the course of the day that we are



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

in trouble then at the end of the day on Monday then
we will have to come in early on Tuesday. I think it
will be all right. So we will make it 10:00 o'clock
on Monday.

---(Whereupon the hearing adjourned at 4:00 p.m.
to be resumed on Monday, the 30th day of
April, 1984, at 10:00 o'clock)

